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BLACK AMERICAN MEN’S RESILIENCY AND PERSISTENCE TO GROW OLD: A MIDWEST QUALITATIVE STUDY

by

Kimberly Ann Walker

A Dissertation Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

in Nursing

at

The University of Wisconsin-Milwaukee

August 2023

ABSTRACT

BLACK AMERICAN MEN'S RESILIENCY AND PERCISTENCE TO GROW OLD: A MIDWEST QUALITATIVE STUDY

by

Kimberly Ann Walker

The University of Wisconsin-Milwaukee, 2023
Under the Supervision of Professor Kim Litwack, PhD, APNP, FAAN

Abstract

As Black American men continue to experience the highest premature morbidity and mortality, few studies have centered on the intersection of class (low-income) and race (middle-aged and older Black men) with multiple morbidity from a critical race approach in the Midwest region of the U.S. Middle-aged Black men have 31% higher death rate than their White counterparts. A qualitative study was conducted by a community health nurse in the spring of 2021 in a metropolitan city. Thirty-one, low-income Black American men were interviewed focusing on their understanding and perceptions of their complex comorbidities, symptom management for quality of life, short and long-term health planning using critical race theory. Thematic analysis and reflexivity were utilized for the dissemination of the men's narrative as they shared their journeys with their resiliency to resist racism and persist to grow old. Two major themes were identified, 1) resiliency to resist oppression and racism, and 2) persistence for quality of life through analyzing the narratives of the participants. The themes were chosen after analyzing the narratives of the participants who identified as low-income Black men with complex co-morbidities and how they understand their health, manage their symptoms for quality of life, and short and long-term health planning. Community health nursing has an important role, with a multidisciplinary approach, to build relationships and trust among this population for higher quality of life and to support this population toward the opportunity to age and grow old. Through further community participative research, advocacy through a collaborative disciplinary approach and policy action, addressing and acting against racism as the root of Black men's health disparities can be eliminated.

Keywords: Racial disparities, resistance, resiliency, symptom management, quality of life, short- and long-term health plan, critical race theory

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I dedicate this to my family. I would not have been able to complete this degree in midlife without their going love and support of my husband, Brian, and three children, Emma, Ethan, and Olive who continue to give me the strength and joy and to recognize and fight for social justice.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CDC	Center for Disease Control and Prevention
CRT	Critical Race Theory
DM2	Diabetes Type Two
HCP	Health Care Provider
HTN	Hypertension
PCP	Primary Care Provider
SDoH	Social Determinants of Health
SES	Socioeconomic Status
UNWM-IRB	University of Wisconsin-Milwaukee Institutional Review Board

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Acknowledgement goes to all my family, friends and faculty that guided and supported me through my PhD journey to increase the science, knowledge, and truth of low-income, middle-aged, and older Black American men with complex health conditions. The stories and experiences of the men from my study as they have resisted with resiliency and have persisted to age on their terms, was an honor and privilege that has further inspired me to move forward in research to improve health outcomes for this aggregate. My goals and hopes are to not only enhance health outcomes for one of the most vulnerable populations in the U.S. but for Black American men to have quality of life until the end of their life on their terms.

Chapter One

Introduction

The qualitative study explored the phenomenon of how low-income, middle-aged, and older, Black American men with three or more chronic diseases perceive and understand their health, while living with social determinants of health and racism. The questions of the study focused Black men's understanding and perceptions of the following: 1) the chronicity and complexities of their health condition; 2) symptom management and quality of life, 3) short- and long-term goals and advanced care planning as it relates to their health through a critical race approach. The anticipated knowledge generated from this inquiry provided new insights to inform how low-income, middle-aged, and older Black American males perceive and manage their chronic conditions to increase symptom management, have higher quality of life and short, long-term goal planning as it relates to their health. The qualitative study utilized the methodology of in-depth, non-structured interviews to explain the phenomenon under examination. The study included thirty-one participants who live in urban and low-income (self-identified) areas in a midwestern city, who identify as Black American males, 40 years of age and older, with three or more chronic conditions.

Chapter one begins with an overview of background and context that frames the study. Following is the problem statement, the statement of purpose and accompanying research aims. Chapter one will include the discussion around the research approach, the researcher's perspectives, and the researcher's assumptions. Chapter one's conclusion will discuss the need, proposed significance and rationale for this research study and the manuscripts that will contribute to science.

Background and Context

Prevalence of Chronic Disease

Aging populations and expanding comorbidities have led to increasingly complex health care. The World Health Organization (WHO) reported that 74% of all deaths in 2022 where attributed to non-communicable disease (WHO, 2022). The WHO considers the greater challenge for healthcare systems globally is the increased burden of chronic disease, where it is estimated that 60% of all adults will have morbidity and disability by 2020 (Collins & Rochfort, 2016; WHO, 2018). Another significant challenge within the U.S. healthcare system is the disproportionate burden of chronic disease among marginalized populations. In the U.S., shifts in the demographics and diversity of an aging population with chronic, life-ending conditions continue to rise (Sopcheck, 2016).

As baby boomers age, the number of Medicare eligible older adults is increasing. The predicted population growths of Americans sixty-five and older among racial minority growths are described (See Table 1; Ortman, et al., 2014).

Table 1. Estimated Population Growth in U.S. for those 65 years and Older.

Year of Estimation	U.S. Total Population of Those 65 years and Older	Minority Groups: Number and Percentage: African Americans, Hispanic, Native American, Asian/Pacific Islanders
2030	>73 million	>1 million or 29 %
2050	>84 million	>33 million or 39%

Over the next few decades, the growth in minorities of older adults will surpass that of non-Hispanic whites. The predicted estimated growth among all populations over the next few decades (see Table 2; Estimated Population Growth in the U.S. for all Populations 65 years and older from 2020-2050; Ortman et al., 2014).

Table 2. Estimated Population Growth in U.S. for all populations 65 years and older from 2020-2050.

Race/Ethnicity	Estimated Population Growth from 2020-2050
Non-Hispanic White	59%
Hispanics	202%
African Americans	114%
Native Americans	145%
Asians & Pacific Islanders	145%

Among minority groups, disproportionate burdens of disability, pain and advanced disease exist where the population is at higher risks of premature onsets of morbidity and mortality from chronic conditions compared to their white counter parts (Johnson, 2013).

Another disadvantage for persons of color and those who live in low-income, are the impacts of social determinants of health where the onset of chronic disease occurs prematurely.

Impact of Social Determinants of Health

As chronic conditions have been a concern among older populations, marginalized populations experience the impact of social determinates of health (SDoH) where chronic conditions have earlier onsets and become extremely difficult to manage with fewer resources. Living with the impact of SDoH affects the following: 1) access to health care; 2) unsafe housing and neighborhoods that include high crime and environmental issues; 3) language barriers and illiteracy; 4) social structures and attitudes (discrimination, racism, mistrust in governments); 5) socioeconomic conditions (concentrated poverty and the stressful conditions that coexist with it); 6) residential segregation; 7) access to education, economic and job opportunities; 8) availability to community resources, to name a few, all impact health outcomes (Healthy People 2020; CDC, 2019; Shaw et al., 2011, Nazoo & Williams, 2011).

Low-income minorities who experience the intersections of class and race experience greater impacts from SDoH. They are at greater risk for premature onset of chronic conditions that become difficult to manage with fewer resources than whites (Ford & Airhihenbuwa, 2010a, Gee & Ford, 2011, Glymour et al., 2014; Shaw, et al., 2011; Williams et al., 2010; Boucher et al., 2016). According to Barr (2014), there are links to living in low socioeconomic status for all races/ethnicities that increase stress and result in poor health. Minorities who are exposed to discrimination, racism, and poverty experience disproportionate rates and have earlier onsets and increased morbidity and mortality as early as midlife compared to their white counterparts

(Cunningham et al., 2017; Harris & Wallace, 2012). The impacts of racism as a SDoH will be discussed.

Racism as a Factor in Health

Race as a factor in health disparities is well documented independent of age, gender, sex or level of education (Paradies, et al., 2015). For African Americans in the U.S., racism is a systemic, organized cultural and social phenomenon where exclusion, discrimination and prejudice is a cause of social and health disparities manifested by both proximal and distal effects, impacting health where measurements cannot always be defined (Paradies et al, 2015). Socially, racism is correlated with substandard employment, education, housing, income, safe housing, access to health services, healthy foods and easy access to illicit drugs and alcohol. Individually, racism forces its deleterious effects of negative cognitive and emotional phenomenon further leading to psychopathy and morbidity as posited from McEwen's Allostatic Load Model (McEwen & Seeman, 1999; Juster et al., 2010).

The Allostatic Load Model proposes that daily stressful events decrease coping mechanisms, genetic makeup through epigenetic effects that damage immune, physiological, hormonal, and neuronal systems from birth to death (Lu & Halfon, 2003; Saban et al., 2014). Epigenetic changes occur when there is a modified expression within the gene rather than the altercation of the gene itself. Epigenetic change is a regular and occurs naturally but, can be influenced by several other factors such as age, environment/lifestyle and disease state or in this case chronic daily stressors of racism (Oxford Dictionary, 2020).

A large body of literature supports that structural, institutional and interpersonal racism disproportionately undermines the health of African Americans (Lukacho et al., 2014). Multiple scholars argue that racism becomes embodied during the life course and negatively impacts African Americans through multiple pathways such as toxin exposures along with social and economic deprivations (Jones, 2000; Krieger, 2012; Lukachco et al., 2014; Williams & Mohammad, 2009). Therefore, racism as a concept is an element of social structure through which social dominant groups maintain privilege, power and control over different types of distributions of health enhancing resources such as knowledge, health and wealth (Feagin, 2000; Feagin & Benefield, 2014; Link & Phelan, 1995).

Poverty effects on Health

A person's socioeconomic status or class impacts their health. Living in poverty or low-income is a prime predictor where a lack in basic human needs occurs such as: 1) adequate clean water, 2) nutrition, 3) shelter, 4) health care, 5) education, and 6) clothing (Brender et al., 2011). According to the Census Bureau's American Community Survey between 2008-2018, African Americans are the second to poorest racial/ethnic group with twenty-two percent. American Indian and Native Alaskan lead twenty-four percent. Yet, in the state of Wisconsin, African Americans are the highest ethnic group, living in low-income at 27.8 % (Kaiser Family Foundation, 2021). African Americans have had the lowest median income over the past 50 years, measured at $35, 398 for single family annual income in 2014 compared to $54, 657 of all other races (Renwick, 2015). In 2000, African American income peaked but unfortunately has been declining ever since. Living in low-income is highly correlated with poor health outcomes, and increased morbidity and mortality with higher incidences of diabetes, heart disease, higher blood levels of lead, obesity, low birthweight. (Noonan, et al., 2016). Low socioeconomic status (SES) further perpetuates health inequities that leads to worse health outcomes.

Low-income Middle-Aged Black or African American Men

One population that is suffering disproportionately are middle-aged, low-income, Black American Men. Black men are 26% more likely to die from heart disease than White men. Black men are also 17% more likely to die from cancer and 86% more likely to die from prostate cancer, killing 13.8 Black men per 100,000 compared to their White counterparts at 7.4 per 100,000 (USA Facts, 2021).

More recently there have been studies done with middle-aged African American men with chronic conditions. Using a Community-Based Participatory Research investigation, forty-two, low-income, African American men, ages 40-65 years, 20 men with chronic conditions and 22 men healthy without disease, were individually interviewed to see what the participants perceived as driving forces of health disparities (Buchanan et al., 2018). The results showed three themes: 1) poverty and unemployment as powerful impacts; 2) factors in different domains do not operate as discrete independent influences but rather react synergistically and 3) perceived social structural constraints have created a deep cynicism about the future with notable divergent reactions, where there is nothing, an individual can do, or paradoxically, a greater sense of personal responsibility (Buchanan et al., 2018).

Within the U.S., racial disparities in men's health are well documented with consistently higher prevalence and poorer health outcomes among African American males across the age spectrum from unintentional or violent injuries to chronic illnesses. African American men have highest all-cause, age-adjusted mortality rates and worst health status of any race or gender in the

U.S. (Ravenell et al., 2006). Although the mortality rates for African American men decreased by 25% between 1999-2015, primarily for those 65 years or older, profound racial disparities persist (CDC, 2017).

In 2015, Black American men had an age-adjusted mortality rate of 1,070.1 per 100,000 as compared to Caucasian men with a mortality rate of 881.3 per 100,000. Additionally, in 2015, the average life expectancy for African American men was 71.8 years in contrast to Caucasian men of 76.3 years (Murphy, et al., 2018). More concerning is that chronic health conditions are impacting African Americans at younger ages than their white counterparts. In 2015, midlife (40-64 years) African Americans had death rates 31% higher than Caucasians in the U.S. from chronic diseases like heart disease, cancer, kidney failure, HIV, stroke, diabetes and lung disease (Cunningham et al., 2017). African American men continue to bear the disproportionate burden of chronic disease and at younger ages (CDC, 2017).

Younger African Americans are living with or dying from diseases that are typically found in older adult Caucasians. These differences appear in African Americans in their 20’s, 30’s and 40’s for premature morbidity and mortality (CDC, 2017). The burden for risk factors of chronic disease is considerably higher in African American men. The prevalence of obesity, including severe obesity, and hypertension is higher in African American men compared to their white counterparts (Flegal et al., 2010; Benjamin et al., 2018).

The pervasiveness of type 2 diabetes in African American men is double that of Caucasian men. African American men have earlier onsets and prevalence of cardiovascular disease and nearly double the premature mortality rates of their white counterparts (Benjamin et al., 2018). The ubiquity of a cardiovascular event or stroke among African American men is 80% higher than Caucasian men with an 60% mortality rate post stroke as compared with their white counterparts. Lastly, Black American men exhibit a greater burden of cancer whether it is related to incidence, mortality or 5-year survival rate, especially with prostate cancer (Benjamin et al., 2018; American Cancer Society, 2018). Increasingly recognized, social determinants of health (SDoH) are factors driving and sustaining health disparities among African Americans. The burden of chronic disease on populations warrants further exploration in how to best address and manage the pandemic. Disease and symptom management are theories and concepts that have been used in health care settings to assist with the management of chronic disease and will be discussed.

Chronic Disease Management

Symptom Management

Before discussing the concept of symptom management, the definition of a symptom is any morbid phenomenon or departure from the normal function, sensation or structure which is experienced by the patient and indicative or disease (Medical Dictionary, 2023) Symptoms can be subjective regarding a disorder of the disease, like nausea, weakness or pain reflecting changes in the biopsychosocial functioning, cognition, or sensations of a person, where a sign is defined as any abnormality indicative of disease and which is detectable by the individual or others (Bender eta al., 2018).

Symptoms can also be objective such as abnormal laboratory test results or findings from a physical exam (Science Dictionary, 2011). Signs and symptoms are crucial aspects regarding health and illness where disruption occurs with social, mental, or physical functioning (Bender et al., 2018). Symptom management is care given to oneself or by another person, to help relieve the symptoms of disease such as cancer pain, dyspnea from emphysema, or side effects caused by treatment of the disease. Symptom management may help a person feel more comfortable but does not typically cure or treat the disease. Early prevention or treatment are the goals of symptom management regarding symptoms of a disease, side effects caused by treatment of a disease, and the social, psychological, and spiritual problems related to a disease or its treatment (National Cancer Institute, N.D.). Disease management will now be discussed.

Disease Management

The definition of disease is a disorder of the function or structure in a plant, human, or animal, especially one that has a known cause with distinct group of symptoms, signs, or anatomical changes (Oxford Dictionary, N.D.). With the changing landscape since the passage of the Affordable Care Act (ACA) in 2010, health care systems struggle to keep up with the evolving health paradigms particularly with population health management (Ahmed, 2016). Improving quality of life while being cost effective is accomplished by preventing or minimizing the effects or symptoms of the disease through an integrated care approach. Disease management will be further discussed and quality of life but first it is important to understand the historical aspects of quality of life as to relate to this research proposal.

History of Quality-of-Life Inquiry in the U.S.

After World War II was over, increased awareness and recognition of social inequalities rose where quality of life interest gained traction among academicians. This new interest among academicians became a driving force to investigate social indicators and eventually subjective research on quality of life and well-being. Well-being is defined as the state of comfort, happiness or prosperity (Merriam-Webster, 2023). Although patients' view of their health has played some role in medical consultation, researchers did not start to systematically collect data and report it until the 1960's to contribute to the health care literature. Further gabs in the literature will be discussed as it relates to quality of life of Black Americans in chapter two.

Quality of life perception by individuals is largely impacted by a person’s lived experience and will be discussed.

Quality of Life from Lived Experiences

Disease management is a concept of improving quality of life with the goal of improving health care costs for those with chronic health conditions (Academy of Managed Care Pharmacy, 2023). The concept of quality of life is the degree that an individual is healthy, comfortable, and able to enjoy or participate in life events (Jenkinson, 2023). Quality of life is subjective as everyone brings their own perspectives about themselves and others through lived experiences. Lived experience of a person is the knowledge that is generated by a person based on the exposure to events, conditions or occurrences then processing to understand and construct meaning. Live experience is more than just reflecting on the event that occurred but rather a recollective account of reflection of the past event and its retrospective impact (O’Leary, 2022). Therefore, quality of life is subjectively contingent on the experiences the individual has had in their life and the living conditions they find themselves in (Jenkinson, 2023). Quality of life as it relates to health care is viewed multidimensional including social well-being, physical, mental, emotional, spiritual, and material (Jenkinson, 2023). Measuring quality of life is important to consider when assessing subjective data among individuals and will be discussed.

Measurements of Quality of Life

Measuring quality of life comes in many broad forms. Generic measurements include health-related quality of life in any individual or any type of patient group. Specific disease measurement of health-related quality of life as it relates to a specific illness. Lastly, individualized measures of quality of life allow what is important to be considered by the patient.

A rating scale of one to ten will be used within this proposed study with one equating to low quality of life and ten being the highest quality of life.

Lastly, disease management empowers those with chronic health conditions by working with health care providers to prevent complications, like acute exacerbations of their disease, while managing it. People with chronic health conditions typically utilize health care resources more which is often not coordinated among health care providers, therefore creating the overuse or underuse of medical care. Disease management can help to improve care for those with chronic conditions (Academy of Managed Care Pharmacy, 2019). Now the differences between symptom management and disease management will be addressed.

Symptom management vs. Disease Management

Although the National Cancer Institute (NCI) defines symptom management in terms of “serious or life-threatening disease” since NCI’s focus is cancer, doctors, and nurses both assist patients to manage their symptoms for conditions that are not life-threatening. For example, a doctor may prescribe a sleeping medication to treat insomnia, a form of symptom management because it is not an attempt to treat the root cause of insomnia. A nurse may provide education on anxiety or increased stress of a patient by teaching them about deep breathing or guided imagery to decrease a patient’s anxiety (Bender et al., 2018). Then in turn the patient is providing symptom management to themselves by taking the sleeping pill to aid with their insomnia or practicing deep breathing when feeling anxious or stressed. These interventions are not an attempt to treat the root cause of insomnia or anxiety which both may be of physical, genetic, environmental, or psychological. Whereas disease management is an approach to health care teaching patients how to manage their chronic disease and will be explained. Disease

Management is a concept as stated above to not only improve quality of life of patients but to help patients better manage their diseases or chronic conditions and better control health care costs. Disease management by health care providers helps patients to take responsibility for understanding how to care for themselves to avoid potential exacerbations or worsening their health problems (Torrey, 2020). An example of this would be teaching disease management to a person with type 2 diabetes and how to maintain their blood sugars within a healthy range. This may include a dietician consultation about ordering anti-diabetic medication, implementing an exercise routine for weight loss, and starting a food journal to see patterns that may impact their blood sugars daily (Torrey, 2020). Disease management may help a person to be cured of their disease or to slow the progression of the disease to preserve quality of life.

Symptom management is one way to manage a disease by avoiding symptoms and preventing exacerbation of a disease (Bender et al., 2018). An example would be a person with a diagnosis of asthma using an emergency inhaler for dyspnea with exercise or activity. The inhaler is not curing the disease but preventing an asthmatic attack and avoiding worsening symptoms or a potential emergency department visit. A person's quality of life is improved by both disease and symptom management, but disease management is the overarching concept and symptom management is perhaps a construct of disease management. Symptom management and disease management among Black American Men will be discussed next.

Symptom management and Disease Management Among Black American Men

Midlife African American males who are low income and with three or more chronic conditions, live with racism and SDoH which may further limit their ability to manage their chronic health due to the many barriers to: 1) health care access; 2) health literacy; 3) socioeconomic stability; 4) education; 5) non-discriminatory health care encounters; 6) transportation; and 7) meeting their hierarchy of needs, such as housing, food or safety (Barr, 2014). Although managing their diseases and symptoms related to their chronic conditions could be empowering, these concepts assume that its user's all have equality and equity in the U.S. society. (Gee & Ford, 2011; Feagan, et al., 2014). A critical social theory, established from the civil rights movement in the 1980's, exists to address the inequalities and inequities for marginalized populations in the U.S. Critical race theory (CRT) spearheads the social injustices from racism and other oppressing marginalities in the U.S. Critical race theory will now be discussed.

Critical Race Theory

The Critical Race Theory (CRT) can have been a growing transdisciplinary, race-equity methodology since the 1980's and has its roots in legal studies and is grounded in social justice. The tenets within the CRT are purposeful to gain modern racial phenomenon, challenge racial hierarchies and increase the vocabulary of complicated racial concepts. According to Creswell (2007) the use of CRT in research upholds the investigator to spearhead racism and race in all aspects of the research and to tackle conventional worldviews and research work (Delgado & Stefancic, 2017).

The epistemology of the researcher is from a critical social philosophy. As a nurse working within low-income housing of adults, class and racial issues have been a poignant concern for the researcher. Through ongoing interactions, observations, and ongoing concerns of health inequities for a population that suffers from many comorbidities, the researcher has found a method to inquire about the social structures and racial constructs through the voices of the participants. To help guide the researcher and address the disproportionate disparities among low-income, midlife, Black American men, critical race theory (CRT) has been chosen as the guiding theory for the proposed research study. CRT examines many aspects of how race along with other stigmatizing traits increases a person’s intersectionality, e.g., of being Black American male and low income, which further oppresses a person (Delgado & Stefancic, 2017)

Discussion

The remainder of this study will focus on symptom management versus disease management as many concepts are already included in this study to explore. Disease management may be considered based on the participants narrative they share during the interviews. Individuals who can manage their symptoms as it relates to their chronic conditions, have benefited from in cancer research where palliative care symptom management is utilized to improve quality of life no matter their prognosis (Kittelson et al., 2015). Symptom management with chronic disease in the literature has focused on self-management of individuals only addressing one or two chronic diseases, which may have further disadvantages for marginalized populations living with SDoH.

Quantitative and Qualitative research has been conducted in the U.S. regarding disease and symptom management among Black Americans with chronic conditions, yet further exploration is needed in this area where gaps were identified through a literature review for this study. The gaps identified surround low-income, middle aged and older, Black or African American men with complex comorbidity and their perceptions and understanding of their complex health through a critical race theory lens. In short, gaps exist among low-income, middle aged and older, low-income Black American men with multiple chronic conditions, since most studies examined in the literature review, have explored Black Americans with only one or two chronic conditions, have not specifically focused on low-income men using critical race theory. Furthermore, most Black Americans have multimorbidity by midlife, therefore exploring their health perceptions about their disease complexity, chronicity, illness trajectory, and symptom management from a nursing perspective is necessary to help assist this vulnerable aggregate of men through advocacy and trust building with the current health care system

The purpose of this study is to explore how low-income, middle-aged, and older Black American men with three or more chronic conditions perceive and understand their health with the following questions:

1) the chronicity and complexities of their health condition

2) symptom management and quality of life

3) short- and long-term goals and advanced care planning

Methods

A qualitative approach was used to further explore health as it relates to comorbidities of low-income, middle-aged, and older Black/African American men. The use of theory in qualitative research provides a broad explanation for: 1) behavior attitudes; 2) theoretical perspective and 3) a guiding lens to study race, gender, class, or other marginalized groups. The perspective lens supported the types of questions asked, informed how that data was collected and analyzed while calling for action or change (Creswell, 2009, pg. 18; Delgado & Stefancic, 2017).

When using qualitative research, four areas of information was needed to address the above identified gaps. These general areas are explained in more detail in chapter three of the methods section and include the following: 1) contextual; 2) theoretical; 3) perceptual; and 4) demographic information. These areas were utilized to further explore the identified areas of inquiry the researcher holds for the study. The specific relevancy and purpose of each area discussed in chapter three as it relates to the voices of the participants (Bloomberg & Volpe, 2008).

In qualitative research, the main strategy recommended to understand the lived experiences of individuals is in-depth interviews (Marshall & Rossman, 2011). In-depth, semi-structured interviews helped to gather experiences, perspectives, and insights from the participants. Due to the sensitivity of the subject and questions that were asked, individual interviews allowed for more confidential disclosure versus the use of focus groups. Using different methods for data collection, referred to as triangulation, developed a comprehensive understanding of phenomenon, increased saturation of data collection, where enhanced validity occurred using multiple sources to collect information (Carter et al., 2014).

Manuscripts

The researcher did a manuscript dissertation. The first manuscript, Critical Race Theory and Reflexivity to Inform Research and Action Against Racialization to Improve Black Men's Health, from the literature review, chapter two, and chapter five of the dissertation regarding the implications of the study to the *Journal of American Men's Health.* The second manuscript, chapter four describe the results of the study, Black Men's Resiliency and Persistence to Grow Old: A Midwest Qualitative Study, either to the *Journal of American Men's Health* or *Qualitative Health Research*. The third manuscript, Critical Race Pedagogy Praxis: Transformation in Nursing Practice, Policy and Education is from chapter five regarding recommendations from the findings to *Advanced Nursing Science*.

Chapter Two

Literature Review

Chronic disease is a public and community health issue affecting many people. As health inequities and disparities persist, worsening health outcomes continue as health care costs rise (Harris & Wallace, 2012). In 2010, it was predicted that by 2050, forty million Americans would have two or more chronic diseases. A new projection now estimates that the increase has more than doubled, where eighty-eight million Americans will be suffering from two or more chronic diseases by 2050 (Raghupathi, W., & Raghupathi, V., 2018). In addition, by 2030, 28% of the U.S. population will consist of minorities and as the number of minorities continues to grow in the United States (U.S.), so will their chronic health care needs (Mingo et al., 2015).

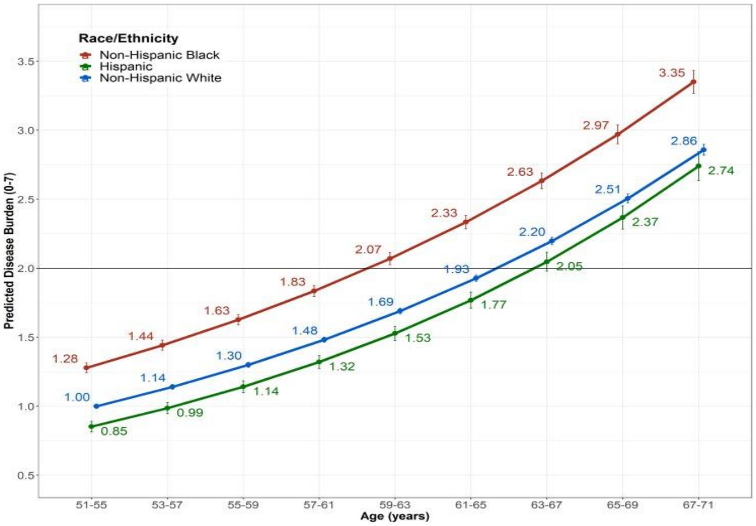
Health disparities continue to rise, but life expectancy and health outcomes have not risen for low-income minority individuals (Chen et al., 2014; Lewis et al., 2011; Gee & Ford, 2011; Ford & Airhihenbuwa, 2010a). Persons living within the intersection of low-income and color face further disadvantages from social determinants of health and racism (Krieger, 2014; Ford & Airhihenbuwa, 2010a; Williams 2010; Williams et al., 2019). Those living with social determinants of health (SDoH) and racism increases their risk for developing chronic conditions which starts earlier in life, leading to shorter life expectances (Gee & Ford, 2011).

Socioeconomic status (SES) is an SDoH which leads to ill-health with increased morbidity and mortality among low SES groups (Lewis et al., 2011). Racism, as a social determinant of health, is considered more as researchers examine the prevalence of health inequities among racial minorities (Gee & Ford, 2011). Studies have found that persons who report experiencing racism exhibit worse health and increased morbidity and mortality (Barr, 2014; Gee & Ford, 2011; Ford & Airhihenbuwa, 2010; Williams, 2010).

Black Americans especially have shown that increased stress from racism predisposes them to earlier onsets of chronic conditions such as cardiac disease, obesity, diabetes, and depression (Barr, 2014). In 2015, Black Americans in the age range of 50-64 years of age, had significantly more chronic illnesses per person and a death rate of 31% higher than Caucasians in the same age group (Chen et al., 2014; Cunningham, et al., 2017).

Most middle-aged adults live with at least one chronic illness but persons of color and/or living in low-income have more than one chronic condition by midlife (Quinones et al., 2019). A longitudinal study examined the racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults (See Figure 1**;** Non-Hispanic Black, non-Hispanic White, and Hispanic trajectories of chronic disease accumulation over time, HRS 1998–2014). Black Americans start with an earlier burden of chronic disease and develop multimorbidity at an earlier age than their White counterparts (Quinones et al., 2019).

Figure 1. Non-Hispanic Black, non-Hispanic White, and Hispanic Trajectories of Chronic Disease Accumulation Over Time, HRS 1998–2014 (Quinones et al., 2019).



Earlier onsets of multiple morbidity and premature deaths are the highest among middle-aged African Americans in the U.S. and most deaths are occurring from chronic conditions with HIV being the leading cause of deaths then cerebral vascular disease, diabetes, cancer, and heart disease to follow, which all occur at higher rates among low-income populations (Cunningham et al., 2017).

Background and Significance

Disparities in Black American Men's Health

The topic of Black American men's health has been a growing concern among policymakers, civic leaders, public and community health providers as the disparities in health outcomes continues to grow (Wade & Rochlen, 2013). Research on these topics more recently has been addressing specific diseases like type 2 diabetes (DM2) and heart disease, which are both prevalent among Black Americans, but few qualitative studies have addressed multimorbidity. Statistical reports along with recent studies have shown that Black Americans have earlier onsets of chronic disease through a lifetime of exposures consisting of direct, indirect racism to structural issues embedded within the U.S. culture and societies that are based on racial discrimination (Barr, 2014; Cunningham et al., 2017; Gee & Ford, 2011; Ford & Airhihenbuwa, 2010a; Williams, 2010; Glymour et al., 2014; Krieger, 2014).

Racism in the U.S. continues from historical traumas to current race related issues. Historical traumas of slavery, current structural racism embedded in the U.S culture, and more recent implicit and explicit biases, has continued to limit equality, equity, and opportunities for persons of color. The limitations are related to: 1) security with socioeconomic status; 2) quality of living conditions; 3) choice of geographical areas to live; 4) quality of education; 5) injustices in the criminal system; 6) quality and timely health care interventions; and 7) mistrust of the health care system, contribute to poor health outcomes and quality of life for Black American men (Alexander, 2012; Adebayo et al., 2019; Barr, 2014; Thorpe et al., 2016; Kwate, 2017; Martin et al., 2013; Nellis, 2016; Schnitter et al, 2011; Song et al., 2012).

Consequently, most research conducted among Black Americans in the U.S. is through the lens of European existentialism. European existentialism is where the presupposition of individual self-determination and accessibility functions as an impediment, therefore, limiting potentially across racial contexts. What is needed for Black American individuals is a philosophical way of seeing, acknowledging, and exploring their experiences and meaning making (Vereen et al., 2017).

Black existentialism provides the philosophical grounding to explore the struggle to live within inequity, racialization, and historical oppression as experienced by African Americans. Black existentialism is concerned with the liberation of people who have historically not been viewed as human (Vereen et al., 2017). Both European existentialism and Black existentialism have similarities where both value agency and liberation whereas the difference is evident in the belief that all individuals have equal access to systems that support agency and liberation. Black existentialism acknowledges the inequity of access for all while challenging the axiom that before agency there must be liberation, the precursor, and necessary foundation to accessing agency that has not been historically afforded to Black Americans (Vereen et al., 2017).

I have been using the lens of Black existentialism throughout my doctoral preparation, as a nurse educator and clinician. This philosophy, with roots in advocacy, social justice, and radicalism, has increased her understanding and view of where inequity, marginalization, racialization is situated as Black Americans search to experience agency in the world. Black existentialism has further aided the researcher's understanding of how the historical traumas, current racialization and dominant White culture embedded in the U.S. society has impacted Black Americans (Vereen et al., 2017).

Furthermore, the pursuit of self-defined collective identity has been a historical theme for Black Americans. This pursuit of identity is due in part to a lived experience of hegemony and the colonization of Black people which further intersects with the denial of physical and psychological freedom. Black Americans exist in a world as a non-White person and as a Black person in relation to the White dominant society. Therefore, Black Americans often lack a consistent homogeneous environment due to their existence in a Black, White, and human world and as a result, the potential for confusion could emerge further creating fractures to self into different yet interdependent entities. Hence, the question that comes for Black American persons is their essence and the freedom to choose, which are the basic elements/constructs of existentialism and humanism which are denied when living in an anti-Black world but challenged through a Black existentialist perspective and a critical lens that encapsulates these elements, critical race theory (CRT).

Critical Race Theory

As the lead for this study, it was important for me to first consider my positionality in society as a White, middle-class, middle-aged woman born and raised in the U.S when using CRT as the guiding theory for my research. Through deep reflection and reflexivity and the education and the scholarship works of Dr. Robin DiAngelo, a White woman, and sociologist, the student researcher has been able to recognize the very nature of a lifetime of White experiences in a racialized society and culture (DiAngelo, 2018). The White experience is neither universal or objective yet the Western, U.S. culture has two key ideologies of individualism and objectivity. These two key ideologies make it exceedingly difficult for White people to explore the collective aspects of the White experience (DiAngelo, 2018). Therefore, I continue to set aside my narrative and grapple with the collective message that all Whites, among the shared culture receive racialized views. I practice White humility while acknowledging I am not exempt from the unavoidable dynamics of racism (DiAngelo, 2018).

As a White person born and raised in the U.S., I am a product of the U.S. culture and not separate from it. Modern racism cannot be understood if White people will not explore patterns of group behavior and their effect on individuals (DiAngelo, 2018). The realization that racism is structurally embedded socially and culturally in the U.S. and further perpetuates racial disparities among people of color, inspired me to act and focus on this population for her dissertation study (DiAngelo, 2018). Since my philosophical views are from a critically social view, the use of CRT was chosen as the best theory to guide me in this pursuit and will now be discussed.

Critical race theory was first developed in the late 1970s to ignite further social justice that continued to surround racial issues in the U.S. since post-civil rights efforts were declining. Derrick Bell is considered the father of this theory which originated in legal studies (Delgado & Stefancic, 2017). In 1991, Bell gave a sobering speech, “Racism is here to stay: Now What?” This angered many as he spoke the truth about racism. He stated, “That our society continues to have racism internalized and institutionalized to the point that it is essential and inherently a functioning component” (Bell, 1991, p. 88). He further shared that the U.S. lives in a culture where racial discrimination has been a regulating force for stability and growth for other cultures to maximize from.

Bell stated there is an unavoidable truth in the U.S. society where there is a belief and determination for White dominance. Racism manifests and is a deeply entrenched determination where Whites build their self-worth by maintaining Black people in a subordinate status (Bell, 1991). He ends his speech with some hope that activism can help and provide some triumph.

Civil rights activists continue with the fight for social justice. One truth that drives the use of the CRT is that racism exists. Although this one truth exists, the experiences, beliefs, and perspectives of people of color regarding racism can be different, as no one person lives within one unitary identity (Delgado & Steffancic, 2017) Everyone lives within potentially conflicting and overlapping identities or living within the intersections of many identities, for example, a Black American who lives within a low-income socioeconomic class (Delgado & Steffancic, 2017). (Delgado & Steffancic, 2017). Intersectionality is a way of understanding and analyzing human experience while living in a complex world (Collins & Bilge, 2017).

Scholars, activists, and researchers have sought to find how racism impacts those most affected by it. Since the origination of CRT, it has integrated transdisciplinary methodologies from the disciplines of education, sociology, cultural studies, ethnic studies, women's studies, philosophy, political science, psychology, and most recently public health (Solorzano et al., 2000). Critical race theory was created due to the ongoing racial issues in the U.S. that have led to social injustices and racial health disparities from structural racism (Ford & Airhihenbuwa, 2010b). These issues continue to inhibit social equities economically, legally, politically, emotionally, mentally, and physically. Critical race theory is not like most theories but rather a dynamic philosophy to guide those who use its framework in their work. The tenets of CRT will now be discussed.

The first tenet of the CRT is that racism is ordinary, not aberrational but rather an everyday occurrence for persons of color in the U.S. The feature of racism as ordinary is difficult to address or cure because it is not acknowledged. Rather, the concept of color-blindness is now used to demonstrate that everyone is equal, which only remedies blatant forms of discrimination (Delgado & Steffancic, 2017).

The second tenet or feature of CRT is called interest convergence or material determinism, which advances both working-class Whites mentally, and wealthy or elite Whites materially. There is little incentive to eradicate racism since it benefits large segments of U.S. society (Delgado & Steffancic, 2017).

The third tenet is that race is socially constructed and is the product of social relations and thought. Race is not inherent, fixed, or objective and does not correspond to any biological differences but is a category that society manipulates, invents, or retires from when it is convenient.

Differential racialization is the fourth tenet where the dominant society racializes different minority groups at different times in response to shifting needs such as a labor market.

An example of this would be at one time the need for Mexican or Japanese agricultural workers (Delgado & Steffancic, 2017).

The fifth tenet is intersectionality, which was described earlier, and the sixth tenet concerns the unique voice of color, where different groups of color may be able to communicate to their White counterparts about their experiences and histories with oppression (Delgado & Steffancic, 2017). Being of minority status, in other words, presumes with it the competence to speak about race and racism (Delgado & Steffancic, 2017).

Kimberle Crenshaw (2011) shared her sentiments regarding the CRT from her legal perspective. She felt that the CRT is not comprised of themes, theories, or practices but rather constituted by convergences and contestations on the ways racial power is articulated and understood in the post-civil rights era. She further suggests that shifting the frame of CRT to a dynamic rather than a static reference would be productive means to link CRT's past to the contemporary.

Ford and Airhihenbuwa (2010a) describe CRT as not a "theory" like some of the epidemiological or behavioral theories but instead, it serves as an iterative methodology to guide investigators to remain attentive to equity during their practice, research, or scholarship. Scholars should be diligent to transform the hierarchies they identify through their research as well. The student researcher continues to be reflexive throughout her dissertation using a critical race lens and with the remainder of the literature review. Next, the discussion of how racism and social determinants of health impact Black American health.

Impacts of Racism

Impacts of Racism on African American Health

A study conducted in the U.S. found that eighty percent of Black American respondents reported experiencing racial discrimination at some point in their lives. One in every eight Black Americans experience some form of racial harassment in the past year in the form of racial insults, repeated victimization, and nearly a quarter of the minority respondents were fearful of racial insults (Nazroo & Williams, 2011).

The effects of racism have been an area of growing focus in the U.S. where both implicit and explicit racism along with structural racism affect African American health (Gee & Ford, 2011; Ford & Airhihenbuwa, 2010b; Williams & Mohammad, 2009). Studies have shown that African American men experience racial harassment and discrimination more frequently than African American women and further research suggests that the experience of racism may be qualitatively different for Black men and Black women (Wade & Rochlen, 2013; Wesley, 2015).

Black American men's repeated encounters with prejudice and racism perpetuate an "invisibility syndrome", which is defined as "an inner struggle, feeling that one's talents, personality, abilities, and worth are not valued or recognized due to prejudice and racism. The invisibility syndrome further fosters inherent stress for Black American men as it impacts the management of their identity (Wade & Rochlen, 2013). The repeated prejudice and racism that Black American men face has shaped their masculinity.

Impacts of Racism on Black American Men's Masculinity

To contextualize masculinity for Black American men, in a White dominant culture, examining how racial minority groups define masculinity is necessary. Hegemonic masculinity, a sociological theory, argues that masculinities for nondominant groups (e.g., racial minorities) have taken forms that have been strongly influenced by their subjugation or marginalization within their respective societies (Wade & Rochlen, 2013). Therefore, considering the masculinity of a Black American man needs to account for not only the White Western masculine norms but the racial oppression and its effects. Black American men's masculinities are a dynamic product of negotiations between the minority and majority cultures where contention of ongoing racial oppression continues to threaten their identity and masculinity (Rogers et al., 2015).

The impact of the historical trauma of slavery to the current and prevalent racialized U.S. society has shaped the masculinity of today's Black American man. Most young Black men acquire power by stylizing their bodies over space and time in such a way that their bodies reflect their uniqueness and provoke fear in others (Wade & Rochlen, 2013). Another name for these behaviors is "cool pose" that is a ritualized form of masculinity which entails scripts, behaviors, impression management, physical posturing, and carefully crafted performances that deliver a single critical message: strength, pride, and control that is particularly acute among low-income Black American men (Wade & Rochlen, 2013; Rogers et al., 2015). To be "bad" is good, not simply because it undermines the language of the dominant culture but also because it imposes a unique kind of order for young Black men which promotes attention that makes others pull back with some trepidation. This young male style is a form of self-identification and resistance while living in a hostile culture and is also an example of machismo identity ready for violent encounters.

Black machismo, in a patriarchal society, is expected and exalted that solicits violence against women, other Black men, against White men while in prison together, or towards aggressive police. The search for power usually results in a confrontation with the order imposing authorities, the police, and the criminal justice system (Sargent, 2010; Wade & Rochlen, 2013).

The complexity of masculinity on Black American men with chronic conditions was very important to continually reflect upon throughout the entire study, especially since I identify as a White female. The literature of masculinity provided needed insights from both a historical and current context as I prepared to honor and learn more from the experiences of the Black American men I interviewed for the study. Mass incarceration among Black men will be reviewed.

Mass Incarceration Impacts on Health of African American Men

Currently, the U.S. has the highest rate of incarceration in the world (Alexander, 2012). No other country in the world imprisons so many of its racial or ethnic minorities. The U.S. prison system incarcerates a larger percentage of the Black population than South Africa did in the height of apartheid (Alexander, 2012). In Washington D.C., it is estimated that three out of four young Black men in the lowest-income areas can expect to serve time in prison and these rates of incarceration in Black communities across America are similar to those found in the U.S. capitol (Alexander, 2012). The stark racial disparities cannot only be explained by rates of drug crimes since studies have shown that persons of all colors use and sell illegal drugs at a similar rate (Alexander, 2012).

Mass incarceration among Black American men has a racial dimension in the U.S. Since the 1980s, mass incarceration of Black American men in the U.S. is important to consider in how it provides context on both historical, over the past thirty years, and current social issues faced by Black American men (Alexander, 2012). The penal population exploded from 300,000 to more than 2 million in the 1980s with the “war on drugs” campaign, with drug convictions accounting for most of the increase (Alexander, 2012).

African Americans are incarcerated 5.1 times greater in state prisons, but the ratio is even greater at 10 to 1 in the following five states: 1) New Jersey; 2) Wisconsin; 3) Minnesota; 4) Iowa, and 5) Vermont (U.S. Census Bureau, 2013). Wisconsin had the second-highest rate of Black American men imprisoned, for every White man, twelve Black American men are incarcerated. To provide a geographical context for this study, the county where the study took place will reveal incarceration rates within that county and compared to another urban city in WI. The counties of Dane and Milwaukee were chosen as these counties are most populated with African Americans in the state of Wisconsin. Incarceration rates of these two counties provided context and significance of the racial disparities between African Americans and their White counterparts, (See Table 3; Wisconsin Incarceration Rates in Percentages) Nellis, 2016; United Way of Dane County, 2019; Austin et al., 2019; Incarceration Trends, 2015).

Table 3. Wisconsin Incarceration Rates in Percentages

Wisconsin Population rates	Whites 81.1%	African Americans 6.7%
Wisconsin Incarceration Rates per 100, 000	221	2542
Dane County Population rates	84.9%	5.5%
Dane County, WI incarceration rates (2015)	53%	42%
Milwaukee County Population rates	64.3%	27.3%

Milwaukee County incarceration rates (2015)	20%	63%
Wisconsin incarceration rate	52%	42%

The racial disparities of incarceration rates in both Dane and Milwaukee Counties is not representative of the respective county's population of Black Americans. In Milwaukee County, the incarcerated Black population is higher than that of Dane county but also has a Black population five times greater than Dane County. Therefore, the disparity of incarcerated Black people in Dane County is even greater than in Milwaukee County. Also, most Black American men who are incarcerated are low-income and with the additional stress of incarceration, increases their risks of earlier onsets of chronic diseases.

A literature review by Schnittker et al., (2011), investigated articles on previous research on the effects of incarceration on the health of Black Americans on an individual and aggregate-level research. The risks of poor health reflect a transitive logic spanning post-incarceration and other well-established social risk factors such as unemployment, low income, and the unlikelihood of marriage which all impact health (Schnittker et al., 2011). Also, most inmates are first exposed to prison during young adulthood and many health differentials may not appear until midlife when condition rates and disparities across groups become more apparent (Schnittker et al., 2011).

Since more men are incarcerated than women, the stress on the family and communities can be even greater than on the prisoner (Schnitter et al., 2011). The strong social stigma of incarceration on families and communities can have similar impacts of similar illnesses. Once the prisoner is released, supporting his family is challenging with lower wages, unstable employment, discrimination, divorce and eventually contribute far less to their families and live away from them (Schnitter et al., 2011). The rate of recidivism, social isolation, increased use of substance and alcohol abuse, smoking, poor health, and lower quality of life exists for Black American men during and post-incarceration (Mukku et al., 2012). Racialization and discrimination in the U.S. health care settings will be discussed.

Racism & Discrimination in Health Care

There are several obstacles of health care access that are correlated with structural racism. Access to health care limits a person's ability to preventative services until emergencies arise due to lack of transportation or health insurance. Although the rate of those uninsured declined from the Affordable Care Act (ACA) of 2010 for those 18-64 years of age, there remains a difference in those uninsured among Black Americans and Latinos compared to White Americans (Noonan et al., 2016). Besides, not all states implemented Medicaid expansion under the ACA, which largely impacts those who are low-income and are minorities (Medicaid.gov, 2016). According to the Kaiser Foundation, 40% of eligible Black Americans reside in states who have rejected the Medicaid expansion and are twice as likely to be uninsured than Whites and Latinos (Artiga et al., 2016).

Lastly, a study by Han et al., (2015), was done among states who did not expand Medicaid. In this study, low-income adults between the ages of 18-64 years who are more likely to be Black American, are less likely to have a routine care provider, and less likely to use preventative services. Black Americans were more likely to report the inability to see a doctor due to cost. Yet, Black and White Americans equally reported having a primary care provider across all ages (Cunningham et al., 2017). Studies focusing on physical encounters between Black Americans and health care providers (HCP) have shown the interactions between the patient and PCP to be surrounded in biases, discrimination, and racism, which were identified by both the Black American patients and health care providers (Beach et al., 2011; Hausman et al., 2011; Martin et al., 2013; Adebayo et al., 2019; Williams & Cooper, 2019).

Communication barriers between health care providers and their patients surround discrimination, implicit or subconscious bias. According to Abramson et al., (2015), a quantitative study was conducted to examine the perceived discrimination in U.S. healthcare by minorities. The findings indicated racial minorities were more likely to report perceptions of discrimination, which was statistically significant among Black Americans and Native Americans (Abramson et al., 2015). Poor self-reported health and communication difficulties during clinical encounters were associated with increased perceptions of discrimination among all groups (Abramson et al., 2015).

The Council on Ethical and Judicial Affairs of the American Medical Association did a comprehensive review on the issue of racial bias among physicians in 1990 (Barr, 2014). From this report, recent studies have found when Black Americans gain access to health care, they are less likely than Whites to receive certain surgeries, treatments, or therapies (Barr, 2014). A study by Hoffman et al., (2016), found that health care providers, based on false personal beliefs of biological differences between Black Americans and White Americans, routinely undertreat Black Americans who reported pain.

Another qualitative study used focus groups of Black Americans, separated by gender, to discuss their perceptions of communication with health care providers. Perceived discrimination, especially among Black American women, was described when sharing symptoms or their concerns were discredited by health care providers (Cuevas et al., 2016). Black Americans also had fears that contributed to issues regarding their chronic diseases, which will be further discussed in the literature review. Racial segregation will be presented and how this impacts Black American health.

Racial Segregation

Racial segregation is defined as the physical separation of races where housing options for Black Americans is limited to the least desirable residential areas (Moffit, 2015). Segregation emerged in the 19th and 20th centuries to ensure that White Americans were protected from the residential proximity of Black Americans, which was imposed by legislation and supported by major economic institutions. Segregation was further enshrined by the housing policies of the federal government, enforced by the judicial system and legitimized by an ideology of White supremacy, and further advocated by the churches and other cultural institutions (Nazroo & Williams, 2011).

Considerable demographic and socio-economic diversity persist among the major racial/ethnic groups in the U.S. and is further complicated by the geographical and segregation of ethnic and racial minority groups, a prominent theme in the U.S. (Nazroo & Williamsn, 2011). In the first decades of the twentieth century, class and racial segregation increased in the Northern cities as the African American population began to increase with the Great Migration North from southern states (Iceland, 2013). The 1960's and 1970's brought the term "ghetto" as poverty rates increased in these cities resulting from past governmental policies, ethnic and racial discrimination, residential segregation, economic changes, and employment relocations (Iceland, 2013). The low-income areas that were developing in the cities were less desirable to more prosperous persons which started their relocation to the suburbs according to Moffitt and Urban Institute (Iceland, 2013).

Segregation is a key determinant of racial differences in socio-economic mobility and further creates health-damaging conditions in social and physical environments (Nazroo & Williams, 2011). Elevated levels of segregation have distinctive ecological environments that are higher crime, less quality housing, less green space or access to healthy foods further impacting Black American health (Nazroo & Williams, 2011; Williams & Cooper, 2019; Barr, 2014; Iceland, 2013; DiAngelo, 2018). Racial segregation has also contributed to social stratification in the U.S. (Moffit, 2015).

Social Stratification

Social stratification refers to a system that categorizes individuals into levels or ranks creating a hierarchy within its society (Moffit, 2015). Social stratification is based on four principles: 1) it is a trait of a whole society not just a reflection of one individual; 2) is universal but varies within each society; 3) persists over generations; and 4) involves not just inequality but beliefs that are rooted within the society's philosophy (Moffit, 2015; Iceland, 2013). Social stratification across groups occurs when one social group finds methods to maximize their benefits by restricting others to resources or opportunities. For example, the use an external identifiable characteristic of another group such as race, language, religion, or social origin as a pretext for their exclusion (Iceland, 2013).

A similar concept, interest convergence, or material dominance is a core tenet of critical race theory (CRT) which will be used in this proposed study (Delgado & Stefancic, 2017). Interest convergence or material dominance occurs where racism advances the interests of both White elites, materially, and working White class, psychologically, which further perpetuates social and structural racism as large segments of society have little incentive to eradicate it (Delgado & Stefancic, 2017; DiAngelo, 2018).

In 2010, Black Americans only comprised 13% of the U.S. population and have had to contend with more discrimination, including a severely constrained labor market throughout the nineteenth and into the twentieth century (Iceland, 2013). Since the civil rights movements, discrimination and racial segregation still exists but now found in the economic conditions that have an increasing role of determining black disadvantage (DiAngelo, 2018). Economists estimate that a quarter of the Black-White wage gap is a result of prejudice, suggesting that racism continues to add to Black American economic disadvantage and the economic challenges faced by low-income Black Americans remains daunting (Iceland, 2013,). Poverty in the U.S. perpetuates by social stratification where economic and social institutions generate inequality and poverty and will be discussed more.

Racial or ethnic stratification impacts several minority groups far worse than Whites on several social and economic indicators (Iceland, 2013). Minorities on average are more likely to have lower levels of education, wages, employment and are likely to have chronic health problems which are all characteristics of higher poverty rates (Iceland, 2013). Increased concentrated poverty in the 2000s contributed to the overall poverty in that decade, where the Midwest, was impacted the most by continued industrial declines (Iceland, 2013). The impacts of low-income, racial stratification, and racial segregation has led to health disparities or social determinants of health among Black Americans compared to their white counterparts and will be discussed.

Impact of Social Determinants of Health

According to the, CDC, social determinants of health (SDoH) are social and economic conditions that impact health in communities influenced by the amount of power, money, and resources individuals have which are determined by policy choices (CDC, 2014). Social determinants affect health outcomes from factors such as early child health development, amount of education, job sustainability, occupational exposures, food security, access to health services and the quality of these services, income, housing status, social supports, and discriminations (CDC, 2019).

Social inequalities or social stressors continue to exist in the U.S. but are now largely the result of differences in adult mortality. For example, Black men have a twenty-year lower life expectancy than white, wealthy men in the U.S. (Marmot, 2011). Understanding and knowing the social position of a person within the hierarchy of a society predicts health outcomes for that person (Brunner & Marmot, 2011). The social environment impacts biology of individuals that further causes disease by the response to the external demands (Brunner & Marmot, 2011).

Social Determinant of Time

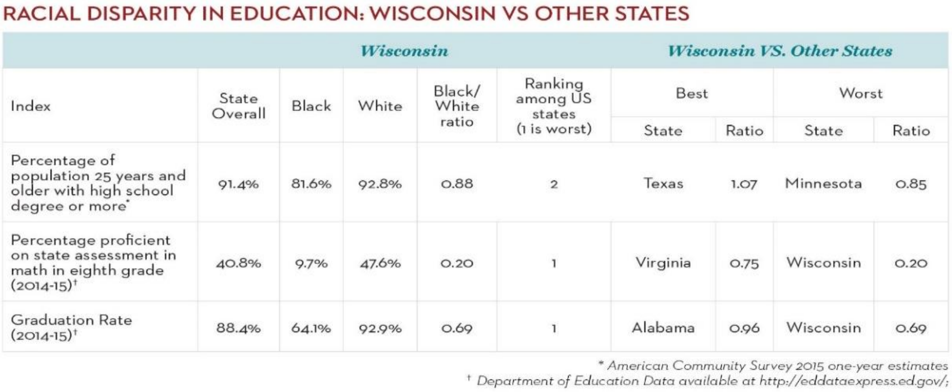
According to Kwate, (2017), time for African Americans is an SDoH in that it perpetuates racial health inequalities. Meaning, that Black Americans in the U.S. experience time lost across multiple domains throughout their life course further positioning them at risk for disproportionate morbidity and mortality. Racialized time indirectly harms health by disrupting or denying access to societal resources structurally limited to Black Americans such as power, money, freedom, prestige, knowledge, and social networks. Racialized time harms the health of Black Americans directly when it produces stress and exacerbates conditions of racialized subordination. Specifically, Kwate (2017) examined three racialized areas for Black Americans 1) spending too much time to meet basic needs, 2) having less time spent on them than is required, and 3) lost years for quality of life. Education and socioeconomic status as a social determinant will be presented.

Social Determinant of Low Education and Socioeconomic Status

Studies and statistical findings have supported that low education attainment, having disabilities, being a child in various areas of the U.S., and being a person of color contribute to low socioeconomic status (Nazroo & Williams, 2011; Iceland, 2013). According to the 2017 U.S. Census Bureau, 24.9% of those without a high school diploma live below the poverty level compared to 12.7% with a high school diploma (Fontenot et al., 2018). More recent data from the U.S. Census Bureau (2017), the proportion of people living at the poverty level in WI was 10.5 % and below the U.S. poverty level of 12.8%, but its neighboring states had lower levels. Minnesota’s poverty level was 8.6%, Iowa’s at 9.7%. Illinois was higher than WI at 11.3% (Fontenot et al., 2018). The census report stated that poverty was the highest in large cities, which could contribute to the states of WI and IL, and their larger cities of Milwaukee and Chicago (Fontenot et al., 2018).

More specifically in the state of Wisconsin where I conducted the study, racial disparities in education and economic existences. The American Community Survey from 2015 demonstrates racial disparities among Black versus White education attainment (See Table 4; Racial disparity in education: Wisconsin versus other states).

Table 4. Racial Disparity in Education: Wisconsin versus other States



RACIAL DISPARITY IN EDUCATION: WISCONSIN VS OTHER STATES

	Wisconsin					*Wisconsin VS. Other States*			
Index	State Overall	Black	White	Black/ White ratio	Ranking among US states (1 is worst)	Best		Worst	
						State	Ratio	State	Ratio
Percentage of population 25 years and older with high school degree or more*	91.4%	81.6%	92.8%	0.88	2	Texas	1.07	Minnesota	0.85
Percentage proficient on state assessment in math in eighth grade (2014-15)†	40.8%	9.7%	47.6%	0.20	1	Virginia	0.75	Wisconsin	0.20
Graduation Rate (2014-15)†	88.4%	64.1%	92.9%	0.69	1	Alabama	0.96	Wisconsin	0.69

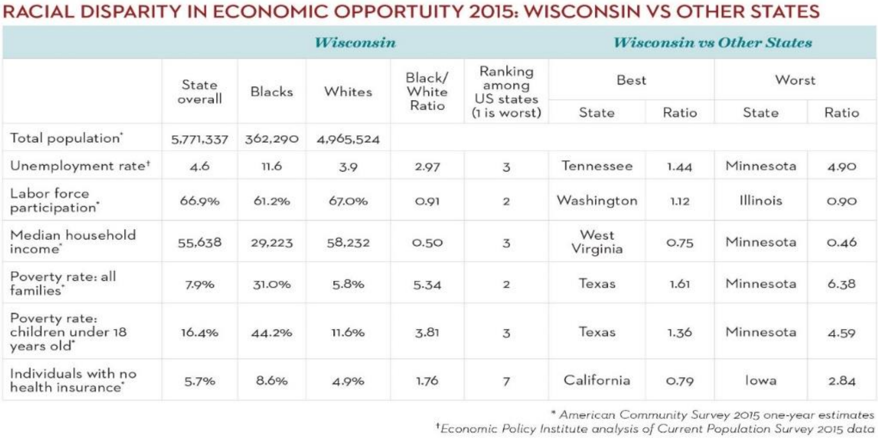
* *American Community Survey 2015 one-year estimates*
† *Department of Education Data available at http://eddataexpress.ed.gov/;*

The graduation rate of 64.1% and the eighth-grade math proficiency assessment of only 97% among Black Americans are both far less than their White counterparts.

Living as a minority in the U.S. leads to lower educational attainment, employment opportunities, and income equity (Glymour et al., 2014). Black Americans are the poorest race/ethnic group in the U.S. (Iceland, 2013). According to the U.S. Census Bureau, in 2017, 21.2% of all Black Americans were below poverty compared to 10.7% of Caucasians (Fontenot et al., 2018). The median household income in 2014 for Black Americans was $35, 398 compared to $53, 657 for all other races (Fontenot et al., 2018).

There are greater racial disparities with socioeconomic status (SES) differences in the state of Wisconsin (WI) for Black Americans. According to the American Community Survey, the rate of unemployment, median household income, poverty rates of children and families, and those without health insurance are significantly higher (see Table 5. Racial disparity in Economic Opportunity 2015: Wisconsin VS other states.

Table 5. Racial Disparity in Economic Opportunity 2015: Wisconsin Versus Other States



RACIAL DISPARITY IN ECONOMIC OPPORTUITY 2015: WISCONSIN VS OTHER STATES

	Wisconsin					*Wisconsin vs Other States*			
	State overall	Blacks	Whites	Black/ White Ratio	Ranking among US states (1 is worst)	Best		Worst	
						State	Ratio	State	Ratio
Total population*	5,771,337	362,290	4,965,524						
Unemployment rate†	4.6	11.6	3.9	2.97	3	Tennessee	1.44	Minnesota	4.90
Labor force participation*	66.9%	61.2%	67.0%	0.91	2	Washington	1.12	Illinois	0.90
Median household income*	55,638	29,223	58,232	0.50	3	West Virginia	0.75	Minnesota	0.46
Poverty rate: all families*	7.9%	31.0%	5.8%	5.34	2	Texas	1.61	Minnesota	6.38
Poverty rate: children under 18 years old*	16.4%	44.2%	11.6%	3.81	3	Texas	1.36	Minnesota	4.59
Individuals with no health insurance*	5.7%	8.6%	4.9%	1.76	7	California	0.79	Iowa	2.84

* *American Community Survey 2015 one-year estimates*
†*Economic Policy Institute analysis of Current Population Survey 2015 data*

Low Socioeconomic Position on Health

Poverty is a critical issue in the U.S. with many short and long-term consequences. First, the hardship that accompanies poverty has adverse effects on individuals’ psychological and physical well-being. Children raised in poor families are less healthy, less cognitively developed, have worse academic achievement, low emotional well-being, and eventually, as adults, die at younger ages (Iceland, 2013). Second, there are broad economic consequences from increased rates of poverty since economies thrive in societies with the vibrant middle class, and third, there are serious political and social consequences with elevated levels of poverty (Iceland, 2013). As low-income people often feel alienated from mainstream society, poverty provokes social disorder, crime and reduces public confidence in democratic institutions where individuals don’t feel supported by the prevailing system (Iceland, 2013).

Locations of poverty vary by region in the U.S. and were more concentrated in central cities in the 1970s and 1980s but have now decreased (Iceland, 2013). In more recent years, suburban and pockets of rural poverty have become more widespread where social problems such as crime, welfare dependency, drug use, and substandard educational outcomes are more common in areas of high poverty (Iceland, 2013; Barr, 2011) The lack of economic opportunities and high levels of ethnic, racial and class segregation exist in high poverty areas too (Iceland, 2013).

Characteristics of low-income populations are described as marginalized, or socially excluded. Living in low-income further indicates the degree to which persons suffer from multiple forms of social deprivation, including consumption of goods, employment, social interaction, and political engagement (Iceland, 2013). Also the longer a person remains in poverty the less likely that one will escape it (Iceland, 2013).

Living in low SES increases risks for food insecurity, transportation, and health care access, which all are SDoH and essential components to health (Marmot & Wilkinson, 2011). Deprivation of food nutrition, adequate housing, safety, sense of well-being, mental health, access to health care, and transportation are resources that are needed in low-income communities for a better quality of life (Shaw et al., 2011). Within low-income neighborhoods, food deserts exist without easy access to supermarkets with fresh produce and other healthy foods (Barr, 2014). Several studies have shown in low-income, Black American neighborhoods, there are less fresh and lower quality of food in the supermarkets and contrast, have numerous alcohol outlets where obesity and diabetes prevalence are high within these neighborhoods (Noonan et al., 2016; Gaskin et al., 2014).

Socioeconomic Position and Race/Ethnicity on Health

Differences exist in health across ethnic groups as it relates to morbidity and mortality in the U.S. However, factors underlying such differences remain contested particularly the significance of social determinants and social inequalities that ethnic minority groups face (Nazroo & Williams, 2011). The racial differences include: 1) quality of education; 2) the income returns for a given level of education or occupational status; 3) assets or wealth associated with a given level of income; 4) purchasing power of income; 5) stability of employment; 5) and health risks associated with one's occupation (Nazroo & Williams, 2011). White Americans have higher incomes than Black Americans, who live below the poverty level, and Black Americans are more likely to remain in this situation, less likely to become homeowners and have lower wealth levels than Caucasians (Nazroo & Williams, 2011). Therefore, socio-economic position, when indexed by income for an area of residence, is a considerably more important determinate of Black- White differentials in mortality than behavioral factors, such as cigarette smoking or diet to the extent that diet influences serum cholesterol levels or blood pressure, and biological markers of risks (Nazroo & Williams, 2011).

Evidence exists demonstrating how socioeconomic conditions, across the life course for Black Americans, further influence health status as early as pregnancy or early childhood were both set an adverse biological process in train (Barr, 2014). For example, low birth weight from a mother's circumstances, from her lifetime, is associated with high rates of diabetes, coronary heart disease, respiratory disease, and hypertension in adult life for her offspring and her health (Barr, 2014). Similarly, short stature, influenced by poor nutrition earlier in life, can be related to an increased risk of cardiovascular or respiratory mortality (Nazroo & Williams, 2011). The impact of socio-economic disadvantage on health can accumulate across the life span or "weathering" for the health of Black women in the U.S. (Nazroo & Williams, 2011). Impacts of living with SDoH or chronic stressors will be shared.

Chronic Exposure to Stress or Social Determinants of Health

Ongoing exposures to external demands or chronic stress are common in the current urban environment. For example, the average life span of Black American men in Harlem, despite much higher living standards, is shorter than men in Bangladesh. Psychosocial factors and their influences on health are active areas of research to improve public health in both economically developed and developing countries (Brunner & Marmot, 2011).

The physiological impacts from decades of chronic stress increase risks for diabetes and cardiovascular disease for those farther down on the social hierarchy or lower-income populations (Brunner & Marmot, 2011). The physiological response or sympathoadrenal pathway is initiated with acute stress, which then a slow component of the stress response is the hypothalamic-pituitary-adrenal axis (HPA) pathway. The HPA pathway results in cortisol and other related glucocorticoid hormones released into the bloodstream (Brunner & Marmot, 2011). These hormones have both psychological and metabolic effects and if repeatedly exposed over time, the reactivity will weaken, and a person will have abnormal or elevated resting levels of these hormones. The allostatic load hypothesis links physical disease to the psychosocial environment via the neuroendocrine pathways (Brunner & Marmot, 2011, pp. 10-13).

The allostatic load, or stress-induced damage, is relevant in cardiovascular disease, infection, cancer, and cognitive decline which is a sign of accelerated aging (Brunner & Marmot, 2011; Barr, 2014). In a longitudinal study allostatic load was investigated of older Americans, where it was defined by measures of five established cardiovascular risk factors, urinary adrenaline and cortisol, and serum dehydroepiandrosterone sulfate (an adrenal androgen). Participants with lower baseline allostatic load scores had better mental and physical functioning. The same group over time had less decline and were less likely to develop cardiovascular disease (Brunner & Marmot, 2011). Living with SDoH increases an individual’s risks for developing chronic disease, or disabilities which further threatens low SES.

Living with Disabilities Increases Risks for Low Socioeconomic Status

Persons with disabilities or chronic conditions, between the ages of 18-64, had a poverty rate of 24.9% in 2017 according to the U.S. Census Report. According to the Center for Disease Prevention & Control (2018), Black Americans are second in the nation leading with one out of four adults living with disabilities compared to White Americans with one out of every five adults. American Indian Alaskan Native is first in the U.S. with three out of every ten adults with a disability. Wisconsin has 19% of its adult population with at least one disability compared to 22.5% nationally but those with disabilities are more likely to have other risk factors that lead to chronic conditions or have increased risks of developing chronic illness (Center for Disease Prevention & Control, 2018).

Adults with disabilities have increased risk factors for developing other comorbidities and other consequences. Table 5, below, demonstrates these findings which are based on national and state percentages from the Center for Disease Prevention Control (2018). The state of Wisconsin is the only state mentioned in this comparison since it is where the proposed study will be conducted. According to the CDC (2018), provides a comparison of consequences of disabilities (See Table 6; Comparison of Consequences for Persons with Disabilities Nationally Versus in Wisconsin).

Table 6. Comparison of Consequences of Disabilities Nationally Versus in Wisconsin

Consequences of living with Disabilities	Persons with Disability in Wisconsin	Persons with Disability in the U.S.
More inactive	36.5%	43%
Have high blood pressure	39%	42.9%
Likely to smoke	34%	30.6%
Be obese	46%	39.6%

Although two of the risk factors are below the national average, adult WI residents with diabetes, lung, and cardiovascular disease are at an increased risk for smoking and obesity. Being a minority in the U.S. increases a person's risk for low SES, premature onset of chronic disease and multimorbidity by midlife. Multimorbidity is difficult and complex to manage. Self-management is a method for patients and healthcare providers to use in the management of chronic illness and will be discussed.

Literature Review

A critical review of the literature was completed to explore aspects of symptom management, quality of life, and short and long-term health goals of low-income, middle-aged, and older Black American men with multimorbidity. The review of the literature contributes to the context, structure, history, sociocultural, psychosocial, spiritual, interpersonal, and the intrapersonal aspects of Black American men in the U.S. with chronic conditions. Critical race theory continues to be utilized to provide context for the understanding of symptom management, quality of life, and health goals among the aggregate of Black Men.

Multiple databases were searched: Google Scholar, PubMed, CINAL, Academic, BioMed, and Ovid using the following terms, *middle-aged African American men perceptions of chronic conditions, understanding of chronic conditions, self-management, symptom management, quality of life, short and long-term health goals,* all from nursing, social sciences, medical and public health (see Appendix A. for the PRISMA flow chart (National Guidelines Clearinghouse, 2009). After duplicates were removed, 120 peer-reviewed articles were identified with one dissertation. The inclusion and exclusion criteria for the final articles included in this review will be discussed.

Inclusion/Exclusion Criteria

After an extensive review of the literature, inclusion criteria for the chosen, peer-reviewed articles were established: 1) published within the past five years, but exceptions were made for historical articles, 2) African or Black Americans and Africans who identify as Americans but born outside of U.S. but have lived in the U.S. since early childhood, 3) studies that included both men and women, as not many studies exist with just African American men, 4) written in English ; and 5) those that focused on health perceptions/understanding of chronic conditions, quality of life/well-being, future health goals and symptom management among Black American men (see Appendix B. Literature Review Evidence Table-Low income, middle-aged and older African American Men's Perspectives and Understanding of their chronic conditions as it relates to symptom management and Quality of Life).

Exclusion criteria included articles that: 1) only focused on intervention of an instrument as it related to symptom management, 2) only focusing on disability from the chronic conditions, 3) or focus was only on behavioral chronic conditions, 4) African Americans less than middle age (40 years), Africans who immigrated to the U.S. as adults; and 5) studies outside of U.S.

The researcher attempts to point out important gaps and omissions within the literature when they became apparent during the review. Relevant issues or contested areas are identified and discussed. Each section of the literature review closes with a synthesis where implications on future research are discussed. Finally, the summary that concludes the chapter describes how the literature review has informed the researcher's comprehension of the work assessed and how the work will contribute to the ongoing development of the study's conceptual framework (Bloomberg & Volpe, 2008).

After meeting the inclusion criteria as addressed above, eleven peer-reviewed research articles and one dissertation from 2000-2019 were chosen and critically reviewed. The immense number of articles found supported some aspects of the research questions but not all parts. Because this study was focused on filling the gap where research was lacking, it was not surprising to find that not all the articles encompassed my research questions using a critical race approach. To narrow down the large literary pool, the focus remained on articles that provided the clearest pattern forward from the evidence found to the proposed nursing study.

The decisions made for the included articles will be discussed. Since the study focused on Black men who were middle aged and older and identified as low-income, about one-fourth of the studies did not meet inclusion criteria since many included women, or many women, or were only higher level of income. Other factors that assisted with eliminating articles included participants being too young or only having mental health disease, identified with other ethnicities or races other than African or Black American, or were from outside the U.S. Not many studies used two or more chronic diagnoses or a critical social or race theory. Nursing studies that met the inclusion criteria were included to further learn about the evidence to support Black men's health. The following area will discuss the qualities of the chosen studies before the thorough analysis of the articles.

Three studies were mixed methods (Dickson et al., 2013; Liburd et al., 2004; Patanwala et al., 2017). Seven investigations were quantitative (Garland, 2014; Cary et al, 2015; Esiaka et al., 2019; Clay et al., 2018; Hu (2007); Bazargan et al, 2019; Rice et al., 2017). Two studies used qualitative methods (Griffin et al, 2018; Shianbola et al, 2018). Four investigations were solely from the discipline of public health (Patanwala et al., 2017; Liburd et al., 2018; Griffin et al, 2018; Garland, 2014). Three studies were from the discipline of nursing (Hu, 2007; Cary et al, 2015; Dickson et al., 2013). The discipline of psychology had one study that was included (Clay et al., 2018). The remaining studies were multidisciplinary from the disciplines of medicine, nursing, pharmacy, psychology (Bazargan et al, 2019; Rice et al., 2017; Esiaka, Shianbola, et al., 2018). All of the articles were from 2013-2019 with one article from 2004 public health which was the only article to use illness narrative framework, which is similar to one of the core tenets of critical race theory (Delgado & Stefancic, 2017). In addition, this same mixed-method study had only African American men with a mean age of 57 years (Liburd et al., 2004). The concepts found in the literature review will now be discussed.

The concepts or key phrases within the reviewed articles relate to perceptions and understanding of chronic disease, self-care & symptom management, quality of life and successful aging as it relates to chronic illness. Three of the studies included perceptions/understanding of chronic conditions (Rice et al., 2017; Liburd et al., 2004; Shiyanbola et al., 2018). Four of the articles pertained to quality of life/well-being (Esiaka et al., 2019; Clay et al., 2018; Bazargan et al., 2019; Hu, 2007). Two studies addressed symptoms of mental health among low-income, middle aged and older, Black American men (Cary et al., 2015; Pantanwala et al, 2017). Another study by Garland (2014), addressed knowledge, attitudes, and beliefs of African American men toward their diagnosis of type 2 diabetes along with their risk factors and how they self-manage. Although self-management is not being addressed in this study, the other concepts of their knowledge of diabetes are a contribution to consider for this proposal. One study addressed successful aging as it relates long-term goals, by Griffith et al., 2018, and the last study, by Dickson et al., (2013), examined self-care practices of chronic illness. The demographic information of the studies will now be presented.

Geographic Locations of Studies

Only one study was conducted in the Midwest (Shiyanbola et al., 2018). Two studies were conducted in the southern U.S. (Clay et al., 2018; Griffith et al., 2018). Four studies were done on the east and west coasts (Liburd et al., 2004; Bazargan et al., 2019; Pantawala et al., 2017). Five studies did not indicate a location in the U.S. (Hu, 2007, Dickson et al., 2013; Rice et al., 2017; Esiaka et al., 2019, Garland, 2014).

Seven of the twelve articles indicated the type of location for their studies. Five of the studies were held in urban areas while two were in rural settings (Rice et al., 2017; Clay et al., 2018; Griffith et al., 2018; Liburd et al., 2004; Bazargan et al., 2019). With only one study found in the Midwest, further investigation is needed in this area of the U.S. as it relates to African American Men living with chronic disease. Socioeconomic and education status among the studies will be discussed next.

Socioeconomic and Education Status

Low-income or socioeconomic status in the studies was specified for single or family income and low education was considered less than twelve years of education. Seven of the twelve studies specifically listed their participants as either all low-income with one of the seven reporting only 36% as low income (Rice et al., 2017; Clay et al., 2018; Bazargan et al., 2019; Hu, 2007; Dickson et al., 2013; Shiyanbola et al., 2018; Patanwala et al., 2017). Three of the twelve studies did not indicate SES or education levels (Garland, 2014; Griffith et al., 2018; Cary et al., 2015). Five reported low education attainment while two had high levels of education, high school and college (Rice et a., 2017; Clay et al., 2018; Dickson et al., 2013; Patanwala et al., 2017; 2018; Shiyanbola et al., 2018).

Based on the provided evidence from each article for the literature review, 47% of all participants were from low income, 20% described as low education, 13% with high levels of education, and 33% not listing either education or class. Although this is a low representation of high income and higher education, the differences in African American men's health did not differentiate and will be discussed further in the discussion of this literature review. The demographics of age, chronic diseases, and gender of participants will be presented from the studies.

Age, Chronic Diagnoses and Gender of Participants

Each study had African American men represented with most studies including African American women, as not many studies with only African American men were found. The participants were middle-aged (40 years) or older and with varying chronic conditions. The study by Hu (2007) only listed an age range of 60-90 years of age, included more low-income women than men, and did not specify the comorbidities of the participants.

Two studies had participants with average ages in their forties. According to Esiaka et al., (2019), included just African American men, mean age of 42 years and did not describe the chronic condition but rather reported each participant living with at least one or more chronic conditions, and an education level greater than twelve years. The study by Rice et al., (2017), had a mean age of 48 years with only African American men with two chronic conditions of hypertension (HTN) and type 2 diabetes (DM2). The next age range within the studies includes the mean ages of participants in their fifties.

Two studies included the mean ages in the fifties. According to Liburd et al., (2004), the study focused on African American men with a mean age of 57 years and with the diagnoses of hyperlipidemia and DM2. Shiyanbola et al., (2018), included both men and women with the mean age of 55 years and with the primary diagnosis of DM2 and with the average number of other chronic conditions of 2.9. The other diagnoses for these participants were not specified. The next age group to be discussed will be participants that are in their sixties and seventies.

Three investigations had participants in their sixties. Griffith et al., (2018), had participants, all African American men, with a mean age of 62 years and no listing of specific chronic diagnoses. Dickson et al., (2013), also had both genders but with more men than women who had heart failure, with the mean age of 62 years. Cary et al., (2015) had the mean age of 62 years and primary diagnoses of depression and symptoms of stress.

Two studies that had participants in their seventies starts with Clay et al., (2018), which was the only study that included African American men with three or more chronic conditions. The chronic conditions include chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), metabolic disease, and neurological conditions with the mean age of participants at age seventy-five. Bazargan et al., (2019) had both genders, but more women participants, with a mean age of 74 years focusing on the diagnosis of COPD. Lastly, three investigations had mean ages of participants in their 60-90s and not middle aged, which is another gap in the literature. The type and focus of each study, along with the theory and disciplines conducting the studies will be reviewed.

Disciplines, Conceptual Frameworks/Theories and Study Focus

Of the twelve studies included for this synthesis two quantitative studies described theories to guide the investigation. The research by Clay et al., (2018), used the life-course theory framework and the study by Garland (2014) used the health belief model. The purpose of the study by Garland (2014) was to assess knowledge, attitudes, and beliefs of African Americans toward type 2 diabetes, risk factors and self-management, whereas Clay et al., (2018) assessed the relationships between categories of conditions regarding physical and mental health-related quality of life scale. The use of the life course framework assisted the researchers identify populations at high risk for unequal health outcomes, for tracking system macro-level organizations and highlights where an intervention may be most beneficial.

The remaining quantitative studies did not discuss the use of theories. According to Esiaka et al., (2019), the focus of the study was the well-being of the participants, who had high education, and living with at least one chronic condition. This same study, from the disciplines of psychology and medicine, found that there was a strong correlation of participants with strong social supports and with ethnic identity to increased perceptions of well-being. The nursing study by Hu, (2007), also concentrated on African American men and women living with comorbidities and their perceptions of health-related quality of life (HRQoL). The results found higher rates of depression and decreased functioning of instrumental activities of daily living (IADLs). Another study examined psychosocial factors associated with functional limitations self-reported limitations in activities of daily living (ADLs) in a sample of 141 African American where a correlation was found between increased depressed and lower ability to perform ADL's (Cary et al., 2015).

According to Bazargan et al., (2019) from the disciplines of public health and medicine, those living with chronic obstructive pulmonary disease (COPD), in an urban city, also reported low HRQoL of older adult participants. The last quantitative study by Rice et al., (2017), examined how African American men, with family histories of prostate cancer, and had diagnoses of hypertension (HTN) and type two diabetes (DM2), and perceived themselves at high risk for developing prostate cancer. This study was from the disciplines of medicine and psychology. The qualitative studies will be discussed as it relates to theory, disciplines, and focus.

According to Griffith et al., (2018) from the discipline of public health conducted interviews with African American men using the theory of successful aging. This study captured the participants' perceptions of what enhances success to aging or inhibits it. This was the only study found that addressed future perspectives of African American men, as it relates to health management. Three studies used phenomenology as a guiding theory and will be shared.

The use of phenomenology was used in one study from the discipline of public health. The study by Shiyanbola et al., (2018) from the disciplines of social administration, nursing, and pharmacy, led focus groups of men and women with DM2 and other non-specified diagnoses to explore their perceptions based of DM2 based on the common-sense model, as the guiding framework. The mixed method research studies will be discussed next.

The first mixed-method study by Dickson et al., (2013) is from the discipline of nursing, included more African American men than women, and used interviews for the qualitative aspect of the study. This study utilized the naturalistic decision-making theory to examine self-care practices and socio-cultural influences of self-care with participants who all had the diagnosis of heart failure (Dickson et al., 2013). The second mixed-method study, Liburd et al., (2004), from the discipline of public health, used the illness narrative framework to help explain and understand the psychosocial and behavioral perspectives of African American men with DM2. The last mixed methods study by Patanwala et al., 2017 was a longitundinal study over eighteen months. The researchers recruited 350 homeless persons on the West coast, who were ≤ 50 years and older to take six surveys regarding stress, trauma, and various others and interviewed them every six months with purpose of the study to describe the prevalence of symptoms among older homeless. Findings indicated that older, experienced adults who were homeless, experienced moderate to high physical symptom burden.

Themes from Literature Review

Desite the differing demographics and types of studies included in the literature review, there were similar results and themes identified. Themes were identified that included six barriers and five facilitators regarding African American perspectives and understandings of their chronic conditions, symptom management, and quality of life. The barriers found in the literature review will be discussed next.

Barriers

Both qualitative and quantitative studies revealed participants' barriers regarding their chronic conditions. Six barriers were reported and identified by the participants in the literature review: 1) decreased quality of life; 2) loss of cultural identity and autonomy; 3) denial, masculinity, avoidance, and fears; 4) communication biases and issues with healthcare; 5) knowledge deficit about health condition; and 6) racism and discrimination. The first barrier or negative theme to be identified is decreased quality of life (Clay et al., 2018; Bazargan et al., 2019; Dickson et al., 2013; Liburd, et al., 2004).

Decreased Quality of Life

A relationship between living with low-income and low education was found as it relates to low quality of life (QoL), disability, and higher mortality rates while living with multimorbidity (Clay et al., 2018). This article was the only article that listed multimorbidity (more than two) and specified areas of diseases that included metabolic syndrome, kidney, neurological diseases, COPD, and heart disease (Clay et al., 2018).

A quantitative, nursing study by Hu, (2007), with more low-income and low educated African American women than men, reported lower quality of life. The study assessed the quality of life among low income, 60 years and older, African Americans with comorbidities to compare their results to the general population. The other aim of the study was to see the relationship between reported quality of life with comorbid distressing symptoms and depression rates. The report of the low quality of life was associated with an increased rate of symptoms, depression, and lower functioning by independently performing activities of daily living

(IADL's). The findings of the study were congruent with other studies, with some potential biases since it was a convenient sample. The findings also did not include how socioeconomic status contributes to all the findings, further skewing results or provide specific chronic diseases.

Two quantitative studies showed that African Americans who were low-income had chronic diseases and reported their quality of life to be low (Bazargan et al., 2019; Clay et al., 2018). According to Clay, et al., (2018), those with multimorbidity examined how SDoH impact their health. Furthermore, the study demonstrated how low-income and low education level were associated with low quality of life and was associated with low-quality mental health. The participants described how the disparities they faced through life not only influenced but fluctuated over time through micro and macro experiences (Clay et al., 2018).

A mixed-method study, by Dickson et al., (2013), were mostly men, where 33%, were immigrants but grew up in the U.S. since early childhood and identified as African American. Of the participants, 46% of them reported less than high school education, were low-income, and overall stated they had poor self-care. The participants attributed their poor self-care to the lack of adherence to the recommended healthy diets and not monitoring their symptoms. Many of the participants were influenced by their cultural beliefs and social norms. They discussed how being more financially stable increased their health care access and therefore increased their self-care and management of symptoms. For some of the participants who had moderate physical limitations, they reported how they couldn't participate in culturally supportive activities and were reluctant to ask for help, further contributing to their low quality of life.

The other mixed methods study by Liburd et al., (2004) sampled only American men with hyperlipidemia and DM2. The illness narrative framework guided the study to examine and understand the psychosocial and behavioral perspectives of African American men. The demographics were not clear for the participants, but many believed their diet contributed to their diagnosis of DM2 and reported experiencing many symptoms before they were diagnosed. Many reported that managing their DM2 was very stressful, causing an emotional toll on them and depression and reports of poor quality of life. The last mixed methods study by Patanwala et al., (2017), also identified correlations between older adults who experience homelessness to have higher symptom burden and decreased quality of life.

Loss of Cultural Identity & Autonomy

Participants in four of the studies described how they felt stress, loss, and conflict with their cultural preferences. Two mixed method studies and one qualitative study discussed how challenging it was to manage their diseases due to the dietary restrictions and how it interferes with their cultural preferences from high fat to high sodium diets (Dickson et al., 2013; Liburd et al., 2004). The study by Shiyanbola et al., (2018) revealed how family relations, due to the food restrictions, were strained and participants felt that their autonomy, independence, identity, and sexual encounters were impacted from living with DM2. Participants from the study by Liburd et al., (2004) also expressed concerns and stress regarding their inability to perform sexually and trying to manage DM2 was reported to be stressful for the participants and their partners. According to Dickson et al., (2013), those who were moderately physically impaired from their heart failure shared that they could not participate in culturally based social activities such as large meal gathering with family and friends, a further loss for them.

Denial, Masculinity, Avoidance & Fears

Denial and avoidance were described by African American men as a significant barrier to their health. Four studies had participants who ignored their symptoms of the diseases of diabetes or heart conditions, avoided following up with a health care provider (HCP) or seeking help for their symptoms (Clay et al., 2018; Liburd et al., 2004; Griffith et al., 2017; Dickson et al., 2013).

Participants related their avoidance or denial of their symptoms or diseases because of their manhood or masculinity, which as stated earlier is a strong aspect of African American men's identity (Clay et al., 2018; Liburd et al., 2004; Griffith et al., 2017; Dickson et al., 2013). Masculinity among African American men impacts their perceptions of their health and abilities to manage their chronic conditions. The studies by Griffith et al., (2018) and Liburd et al., (2004) emphasized the importance of self-reliance, independence and ability to survive without the help of others. The studies by Cary et al., 2017 found that if Black Americans reported higher stress and depression their ability for independence decreased but no rationale for the increased depression was identified, nor specificity of the genders/sexes of the participants.

Other African American men reported they carried the burden of their heart disease and would not seek help or limited who they would confide their chronic conditions to (Dickson et al 2013). According to Liburd et al., (2004) and Shiyanbola et al., (2018), trying to manage DM2 was stressful to them and their partner while impacting their ability to sexually perform, another consequence for African American men and their masculinity. Garland (2014) found that the older the participants were, the more negative they were about their DM2.

Fears were expressed in the study by Liburd et al., (2004). The participants shared they had severe symptoms of diabetes before they were diagnosed and could not accept that they had the disease or the need for medication to manage it. Another study identified both fears and anger. According to Shiyanbola et al., (2018), participants, both African American men, and women, mostly all college-educated, were fearful of the consequences from DM2. The participants revealed that they feared death from DM2, amputations, and worried their children or other family members would get the disease. The participants expressed fear and anger due to the loss of autonomy as an employee and how DM2 interfered with their social engagements with dietary restrictions since food is culturally and socially valued. The participants also expressed frustration and anger from symptoms, attributed to DM2, which interfered with their sexual encounters (Shiyanbola et al., 2018). Communication barriers healthcare will now be discussed.

Communication Biases and Issues with Healthcare

Concerns with health care provider communication was shared by African Americans in the qualitative studies. The participants felt their ability to manage their health was complicated by inconsistent health care providers and limited resources. Yet, African Americans with less than high school education, unemployed and/or living in low-income, reported that they did what the doctor said as part of their management and taking their medications was essential to live a long life (Dickson et al., 2013). African American men felt there were communication issues with their HCP which further contributed to their avoidance of seeking health care (Shiyanbola et al., 2018)

Knowledge Deficit about Health Condition

A quantitative study by Rice et al., (2017), examined men with DM2 and/or hypertension on their perceptions for screening for prostate cancer. The participants who were fifty years and older, with less than a high school education and who earned less than $20,000 per year and unemployed, felt they had a very high risk of prostate cancer, whereas all men with a diagnosis of hypertension and a family history of prostate cancer reported a risk of developing prostate cancer. The African American men, with mean age of 48 years, believed their risk for prostate cancer were equivalent to or lower than men within the same age-range. Prostate cancer is a significant health risk where disproportionate rates exist between African American men and Caucasian men and will be discussed further with racism and discrimination (Fletcher et al., 2020).

Phenomenology was used in the study, from the disciplines of nursing, social sciences, and pharmacology, which found that many of the participants, mostly college educated with DM2, felt that historical and current issues have contributed to African Americans developing high prevalence of diabetes (Shiyanbola et al., 2018). The participants believed that past slavery, the current government policies, discrimination, and racism felt from health care providers, and even God has caused high rates of DM2 among African Americans (Shiyanbola et al., 2018). Lastly, a study through the discipline of public health found that African American men viewed DM2 as a normative disorder among African American communities and that they inherited the disease, where DM2 is perceived as a racialized disease (Liburd et al., 2004).

Facilitators or Supports

Facilitators to African Americans and their chronic diseases were reported by the participants in the reviewed studies. Five described facilitators were noted within the literature review. The facilitators identified include: 1) social supports; 2) spiritual and religious practices; 3) health care support; 4) cultural beliefs and practices, and 5) independent strategies.

Social Supports

Both quantitative and qualitative studies with varying socioeconomic backgrounds and education described social supports as facilitators to their health. The role of social support among African Americans as it relates to their health is evident in this literature review as well as another research.

African Americans have other supports outside of marriage within their communities that provide economic security, social stability, and further supported by research (Harris et al., 2010). These findings were found in the literature review, but all the participants were middle-aged and older, reporting either being married, widowed, single or with a partner. The study by Liburd et al., (2004) examined African American men who disclosed their DM2 diagnosis with social supports and surprisingly found that family and friends were supportive of them.

In another study, participants felt that successful aging is how they perceived and defined health. They believed that successful aging also came from meaningful social engagement in life (Griffith et al., 2018). Lastly, the study by Esiaka et al, (2019) participants with more than twelve years of education, found a strong social support system to be strongly correlated with ethnic identity and increased perceptions of their overall well-being. Spiritual beliefs and religious practices will be presented as a facilitator to African American health.

Spiritual Beliefs & Religious Practices

Faith in God was identified as a theme within the literature review as many participants from all education and income levels shared these same sentiments and is further supported from the historical perspectives of African Americans and previous studies. The African American church has been a strong religious and social force of unity for many African Americans. Churches within African American communities have reformed to become major community-based locations with many supports by historically meeting the educational, social, spiritual, civic and health needs of its members and the larger community (Sherman, 2015; Newman et al., 2008). Religion and spirituality are viewed by many African Americans as a significant cultural tie that bonds African Americans together. The leaders within the African American churches are situated to encourage, influence, and guide faith-based interventions.

Participants stated that the role of religion plays an intricate part in health management where they rely on God to help manage their DM2. The felt they had better management of their DM2 through; 1) their faith in God, 2) belonging to church groups for social support; 3) and prayer for individual coping of their DM2 (Shiyanbola et al., 2018). According to Dickson et al., (2013), African American participants reported that God will provide all that is needed regarding their health and with strong faith, they feel they do not always need to see a doctor, as God does the healing. Therefore, spiritual faith could lead some African Americans with chronic illness to rely on God for healing and decrease or eliminate their responsibility for self-management (Sherman, 2015). The assumption that African Americans who trust in God for healing and have decreased or no responsibility to self-manage does not consider other impacts to these decisions, such as mistrust of the health care system or other limitations from SDoH.

Healthcare Support

The support of healthcare providers, pharmacological treatments, and education with diet and exercise was shared in three of the studies. Taking prescribed medications for their diagnoses of DM2 and other chronic conditions was shared as a high priority for health according to the studies by Shiyanbola et al., (2018) and Dickson et al., (2013). Support from HCP was reported by participants to help with self and symptom management (Dickson et al., 2013).

Independent Strategies

Topics of independence were noted as helpful to some participants in four of the articles. Positive thinking was used by participants to assist them in how to manage their DM2 (Shiyanbola et al., 2018). According to Griffith et al., (2018), self-reliance and survival without help were described as important to the African American men participants. Being resilient to further be independent was dependent on the severity of depression among the Black American men (Cary et al., 2015).

Discussion

The evidence that has been provided from the literature review suggests several gaps and concerns surrounding African American men's health as it pertains to chronic illnesses. Not many qualitative studies have solely concentrated on African American men with three or more chronic conditions. The most current research has focused essentially on one chronic condition, such as DM2 or heart disease, and most predominately with African American women. One study, by Griffith et al., 2018, from the discipline of public health, examined how older African American men's conceptions of health were interrelated with successful aging, which was insightful to future or long-term planning perspectives and understanding of this population.

Studies from public health and social sciences have utilized a critical approach to further understand how African American health in the U.S. stems from structural issues, but no nursing studies were found using a critical race approach. As reported above, CRT has not been used in nursing research except in nursing education and more nursing research is needed using CRT in nursing practices for a more emancipator approach to care. According to the American Nurses Association (2015), the nurse's code of ethics describes the importance of social justice, equality, equity in nursing care, the overall goals to decrease suffering and improve quality of life. Therefore, it behooves the discipline of nursing to have a more critical lens to see how current methods of health may not be meeting these professional goals of care.

Critical race theory has not been utilized often within the science of nursing. The only area of research it has utilized is within nursing education as it pertains to nurse faculty diversity. One article by Beard & Wrenethra (2016) did a qualitative study using CRT as the methodology to address the problem of why nurse faculty of color were not increasing in conjunction with its perspective nursing student enrollments.

Hall & Fields (2013) discussed racism and microaggression that is embedded in nursing education and practice. Their discussion was an in-depth examination of the discipline of nursing critically examining the science of nursing, reporting that some nursing theories are biased and do not account for racial inequities. They recommend more research and intentional proceedings in how research is conducted to address racial issues. There was no mention in the article to utilize the CRT for further nursing inquiry or how to adapt a CRT model that is specific to the domains of nursing.

An article by Hall and Carlson (2016) revisited the concept of marginalization from an article done in the same nursing journal from 1994. There is mention of the CRT and using this methodology to increase nursing knowledge surrounding marginalization but to also include Bourdieu’s model of power in society through micro, meso, and macro levels.

Finally, an article by Wesp et al., (2018), and a team of Ph.D. students and nursing faculty from the University of Wisconsin-Milwaukee, addressed the need for a more emancipator approach to nursing research, practice, and scholarship. The theories of intersectionality, critical race, post-colonialism feminism were presented in detail to address the many issues marginalized patients face and how nursing science needs to advance nursing theories and evidence-based practice which is inclusive for all diverse populations.

There are many deficits within the discipline of nursing that can benefit from further research, scholarship, and practice to increase its race consciousness. Further pursuits will decrease health disparities among marginalized patients, provide more equitable care, and improve health outcomes. It is evident that nursing is in the infant stages of scientifically exploring racial inequities and the intersectionality of patients where further advancement is needed. Critical race theory has been moving into the social sciences quickly over the past decade and the discipline of nursing needs to follow suit.

The use of CRT within research requires action through the empowerment of the community examined, extending the voices of the community, counter-storytelling, to advocate toward policy changes (Delgado & Steffancic, 2017) Through these actions, social justice, health outcomes, and quality of life can be improved to those who are marginalized. With the profession of nursing predominately female and white, nurses need to reexamine how practice, research and nursing science is in alignment with an emancipatory approach.

As current, historical traumas and structures have increased SDoH among populations, health inequities, and disproportionate health outcomes, intersecting identities such as race and class further perpetuate these disadvantages leading to earlier onsets of morbidity and premature mortality. Using the tenets of CRT to examine the complexities of these intersections can break barriers of more biomedical models that are currently being used but not appropriate for all patients, communities, or populations.

Also, most of the current literature focuses on health promotion, prevention, and self-management within the high-risk group mid-life African American men. Yet, no research on midlife African American men addresses advanced care planning and long-term goal setting when this group of men (40-64 years) who have mortality rates that are thirty-one percent higher than White men (Cunningham, et al., 2017). Many of these men will end up dying from invasive procedures within hospitals or intensive care units which may not be their wishes for end-of-life care. Addressing symptom management, quality of life and short and long-term health planning, and advanced care planning can be very challenging among midlife individuals but important to examine and explore with the disproportionate health and mortality rates among this population.

Therefore, a more integrated approach, which includes the discipline of nursing, must be considered with complex chronic illness among marginalized populations. The approach must consider the 1) structural (past and present) discrimination, 2) individual level and use of both implicit and explicit discrimination, and 3) how current research/science methods underestimate the impact of racism on health (Krieger, 2012)

According to research by Feagin & Bennefield (2014), institutionalized and white socioeconomic resources, discrimination, racialized framing from centuries of slavery, segregation, and contemporary white oppression severely restrict and limit access to many African Americans. The limitations and restrictions imposed on African Americans and all Americans of color have led to inadequate socioeconomic resources, health care, and health outcomes. Addressing justly with the ongoing racial “disparities” in health and health care systems requires a conceptual paradigm that accurately and realistically assesses the U.S. society’s white-racist roots and contemporary racist realities (Feagin & Bennefield, 2014; Noonan et al., 2016; Gee & Ford, 2011). The Ph.D. student will now present her research inquiry of study.

Research Purpose and Questions

The proposed study sought to explore the phenomenon of how low-income, middle-aged and older, African American men with three or more chronic diseases perceive and understand 1) the chronicity and complexities of their health condition; 2) symptom management and quality of life, 3) short- and long-term goals and advanced care planning as it relates to their health. Providing a voice to middle-aged and older, low-income African men who suffer disproportionately from multiple chronic diseases provides an opportunity to hear and learn their perceptions, understandings, and goals for their health as they live and struggle with complex morbidities. The action plan after this study can lead to community nurse advocacy and future participatory research with this population with a more emancipator self-management method for complex health issues with community members.

Conceptual Framework

The literature review further added clarity of the conceptual framework of where gaps in the current literature and within the discipline of nursing exist. (Bloomberg & Volpe, 2008). Investigating using a qualitative approach to provide a space for low-income, middle aged and older African American men to share their voices, perceptions and understandings of their complex multimorbidity is important to further identify where needs for this population exist and intersect within a very complex society where racism is embedded and perpetuating their health outcomes. Nursing must be leaders to identify ways to decrease suffering and improve their longevity and quality of life.

The second aim of the study focuses on African American men’s perceptions and understanding of symptom management and quality of life. The literature review helped to contribute to where some studies have addressed this through both qualitative and quantitative methods. Areas requiring further exploration need to include how Black American men who live with racism, poverty and other life-long social determinants of health manage their health so they are symptom free and living with higher quality life regarding their health and all other aspects of their life.

Lastly, the third aim of the study seeks to address short and long-term health care planning. Short-term goals or planning understanding and perceptions are the day to day experiences and actions the men take to manage their health and to remain free of symptoms related to their diseases. Long-term planning and/or advanced care planning is especially important as it relates to complex chronic conditions. Most health care systems in the U.S. have adopted this concept to patients and families and are encouraged by the Centers for Medicaid and Medicare (medicare.gov/coverage/advance-care-planning) and the Center for Disease and Prevention Control, (2018). The proposed concepts of the conceptual model of inquiry will be addressed with the guidance and ongoing reflexivity and use of CRT by the researcher.

Limitations

The literature review has provided additional information to further guide the researcher into the methodological phase of the study. This review was not a comprehensive review of the existing literature and there are limitations to the literature review. Since the researcher performed the literature review independently, some research may have been missed or overlooked. Due to the overarching lens of the critical race theory, biases by the researcher may be interpreted. Yet one of the goals of the literature review is a critique of previous research in the areas of interest for this proposal. Racism along with social determinants of health have been considered regarding Black men's health but the profession of nursing has contributions to provide. Through this literature review, further gaps have been identified and the nursing profession has an ethical and moral obligation to persons who identify as low-income, middle aged and older, Black American men with complex comorbidity to decrease their suffering and enhance their quality life, according to the Nursing Code of Ethics (ANA, 2015).

Conclusion

The presented literature review has provided a scholarly foundation and scientific gap to support the proposed research by the author within the discipline of nursing. The increasing number of persons living with chronic conditions represents a public health issue of growing importance, both fiscally and regarding health care outcomes. Further research is needed to further understand the experiences of Black American men's health through a critical race approach to address the injustices that have led to the disparaging premature morbidity and mortality of this population in the Midwest region of the U.S.

Although this literature identified two studies that used a critical view to assess how social structures impact African American health and management of their diseases, none are within the discipline of nursing. This gap in nursing science provides an opportunity for the discipline to further investigate through a critical race and Black existentialist lens to provide a voice and new narrative to consider when working with low-income, middle-aged, and older African American men patients with complex comorbidities.

Chapter 3

Methodology

I utilized qualitative research to further study the social phenomenon of social determinants of health and racism among low-income middle-aged and older African American men with complex chronic health conditions (Marshall & Rossman, 2011). Qualitative research is a study of inquiry to discover issues or concerns in their natural settings, to describe what people do in their everyday lives and what their actions mean to them. The researcher attempted to interpret or understand the phenomena that was collected as it related to the interplay between the narrative meanings people bring to them and the myriad of social contexts of the participants (Ormston, et al., 2014; Erickson, 2018; Chase, 2018,).

The use of semi-structured interviews was used and was integral to understanding the lives of African/Black American men. Additionally, the application of critical race theory to frame a critical discourse from the voices of the participants provided insights for emancipatory purposes. (Marshall & Rossman, 2011). The use of critical discourse analysis creates a theoretical focus on issues of power and resources that are unevenly distributed across both dominant and marginalized populations, leading to premature morbidity, mortality and low quality of life for African American men (Marshall & Rossman, 2011)

Introduction

The rising issues of chronic illness in the U.S., which is further complicated by health disparities among marginalized populations, requires further examination as social determinants of health and racism contributes to premature morbidity and mortality for African Americans (Quinones et al., 2019; Buchanan et al., 2018; Gee & Ford, 2011; Noonan et al., 2016; Krieger, 2014). As populations live longer and minority groups increase in the U.S., the rate of chronic disease increases with the average person by midlife having at least one chronic condition (Raghupathi & Raghupathi, 2018). Persons of color are more likely to develop chronic disease before midlife and have more chronic conditions than their white counterparts by middle age (Quinones et al., 2019; Buchanan et al., 2018; Cunningham et al., 2017; Harris & Wallace, 2012).

Social determinants of health, racism, social stratification, structural racism and discrimination have all been shown to contribute to early exposures to stress where allostatic loads promote ongoing inflammatory responses leading to chronic disease (Nazroo & Williams, 2011; Barr, 2014; Shaw et al., 2014; Gee & Ford, 2011; Brunner & Marmot, 2011). African Americans are less likely to follow up with healthcare providers for collaborative care to manage their health conditions that help to assure symptom management and increased quality of life (Noonan et al., 2016; Adebayo et al., 2019; Buchanan et al., 2018; Abramson et al., 2015; Collins & Rochert, 2016).

Review of the Literature

Social determinants of health (SDoH) over the past few decades have been gaining traction within the U.S. healthcare system as many populations and communities live with inequities and inequalities within the U.S. that leads to poor health. Inequities and inequalities for African Americans stemming from centuries of racial oppression, historical traumas, structural racism have led to the current social concerns with the uprising of racial issues among law enforcement and African American men (Buchanan et al., 2018; Gee & Ford, 2011; Thorpe et al., 2016; Phelan & Link, 2015). The disproportionate health outcomes and consequences stem from poor, segregated housing, unsafe neighborhoods, low educational attainment, and employment opportunities and living with low socioeconomic status, all of which are SDoH. The added stress of daily exposures to racist and discriminatory encounters contributes to chronic conditions for African Americans (Nazroo & Williams, 2011; Barr, 2014; Buchanan et al., 2018).

As health conditions for African Americans, which can start as early as in utero, both men and women suffer consequences from SDoH and racism. Recent studies have shown that these issues impact African American men differently with worse health outcomes. As African American men endure significantly disproportionate rates of racism compared to African American women, their masculinity is impacted along with increased rates of incarceration compared to their White counterparts, especially in the state of Wisconsin (Nellis, 2016; United Way of Dane County, 2019; Austin et al., 2019; Incarceration Trends, 2015)..

The consequences of the stressors of SDoH and racism for African American men affects them differently than women where barriers of mistrust, discrimination and racism within healthcare encounters, fears, avoidance, masculinity, denial, and mass incarceration has perpetuated poor health outcomes (Adebayo et al., 2019; Abramson et al., 2015, Alexander, 2012; Thorpe et al., 2016; Nellis, 2016; Wade & Rochlen, 2013). African American men’s health is a concern for civic leaders, public health officials and other stakeholders as the health disparities among this population persists (Phelan & Link, 2015; Buchanan et al., 2018; Gee & Ford, 2011; Thorpe et al., 2016; Ford & Airhihenbuawa, 2010).

The disciplines of public health, medicine, sociology, and psychology have been prioritizing further research about the impact disparities regarding African American health with only the discipline of public health starting to examine these disparities through a critical race theory approach (Dubbin et al., 2017). The discipline of nursing examined the health disparities among African American men’s health using critical race theory (CRT) to further assess and examine how the profession of nursing can provide a more emancipatory approach to care for African American men (Wesp et al., 2018).

Nursing research has used CRT within research investigations of academia regarding faculty of color within nursing education but has not used the theory to examine other areas of nursing science and practice (Hall & Carlson, 2016; Beard & Wrenethra, 2016; Hall & Fields, 2013). Therefore, the use of CRT as the guiding philosophical lens for this research investigated how racism impacts living as a person of color, as low-income and with complex chronic health conditions (Solorzano et al., 2000; Ford & Airhihenbuwa, 2010).

As social determinants of health and racism continue to perpetuate poor health outcomes among African Americans, the discipline of nursing explored these barriers using a critical race approach. CRT, not like most theories, is a dynamic philosophy to guide those who use its framework in their work (Delgado & Steffancic, 2017). The proposed study examined the perspectives of middle aged, low-income African American men with complex health conditions, how they manage their health when living with the barriers of social determinants of health and racism.

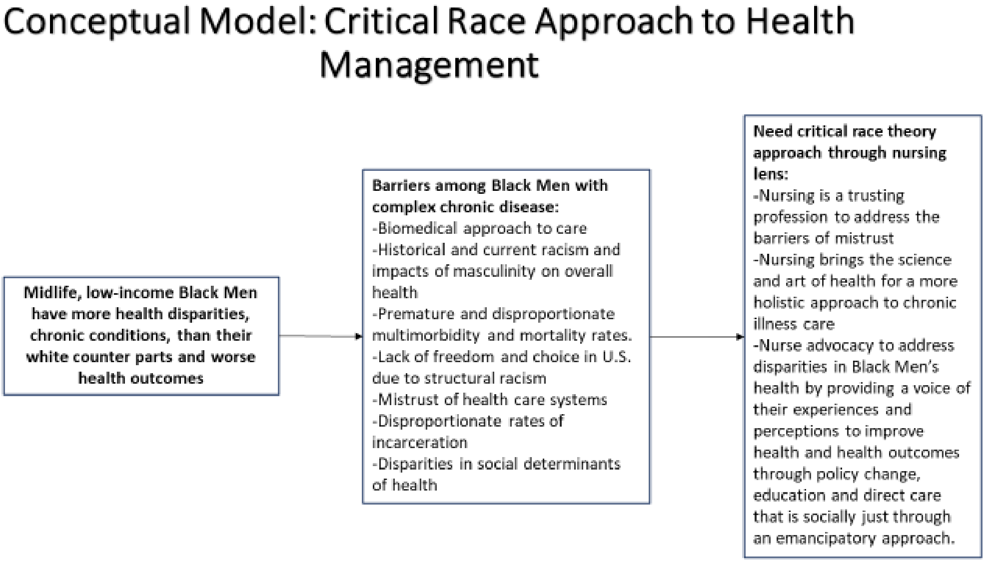
Purpose & Aims

The purpose of this qualitative study explored how low-income, middle-aged (forty years) and older, Black American men with three or more chronic diseases perceived and understood 1) the chronicity and complexities of their health condition; 2) symptom management for quality of life and, 3) short- and long-term goals and advanced care planning as it relates to their health through a critical race approach. In addition, further understanding how they manage their overall health while also living with social determinants of health and racism, utilizing critical race theory.

Conceptual Framework

Based on the information needed to further understand the phenomenon of interest, a description of the data-collection methods will be presented. A conceptual framework was created based on the literature review, historical and current health and social issues, guiding theories to underscore the theoretical grounding for the study and perspectives and experiences of the researcher, (See Figure 2; Conceptual Model: Critical Race Approach to Health Management (Bloomberg & Volpe, 2008).

Figure 2. Conceptual Model: Critical Race Approach to Health Management



Conceptual Model: Critical Race Approach to Health Management

Midlife, low-income Black Men have more health disparities, chronic conditions, than their white counter parts and worse health outcomes

Barriers among Black Men with complex chronic disease:
-Biomedical approach to care
-Historical and current racism and impacts of masculinity on overall health
-Premature and disproportionate multimorbidity and mortality rates.
-Lack of freedom and choice in U.S. due to structural racism
-Mistrust of health care systems
-Disproportionate rates of incarceration
-Disparities in social determinants of health

Need critical race theory approach through nursing lens:
-Nursing is a trusting profession to address the barriers of mistrust
-Nursing brings the science and art of health for a more holistic approach to chronic illness care
-Nurse advocacy to address disparities in Black Men's health by providing a voice of their experiences and perceptions to improve health and health outcomes through policy change, education and direct care that is socially just through an emancipatory approach.

Methods and Procedures

The time frame for the study and how the participants were recruited from the urban community in a midwestern town will be covered. Second, a discourse of the specific kinds of information that was needed to answer the research questions that involve the contextual, perceptual, demographic, and theoretical information. Third, the research design overview will discuss how the research was conducted from data collection to data analysis. Fourth, the data collection methods, collection and the steps taken during data collection will be shared. In addition, how the literature review guided and supported the work that was conducted. Fifth, an explanation of how the data was managed, organized, and synthesized will be discussed. Sixth, how ethical considerations and issues of trustworthiness were addressed in this qualitative research study. Lastly, the limitations and how the researcher addressed the limitations will be explained and end with a chapter summary (Bloomberg & Volpe, 2008).

Participants & Setting

The participants recruited for the study were from urban, low-income communities in a midwestern city, who are middle aged, forty years and older, African American men with three or more chronic conditions (a more detailed inclusion criteria will be discussed in the data collection procedures section). After IRB approval from two required entities was attained, the recruitment strategy involved informational flyers of the study that were distributed within all the communities, (See Appendix C). The period of the study was March 2021-May 2021.

The nurse researcher informed various stakeholders, managers of apartment buildings and gate keepers regarding the research study and its purpose. Community leaders were agreeable to have recruitment flyers hung that indicated the following:

·Who is eligible to participate

·Purpose of the individual interviews

·When the study will occur and time frame of interview

·Token of $30.00 cash as an appreciation for each participant after the interview

·How to inquire about the research study by phone or email

The flyers were hung in community buildings and available for distribution to community members within the neighborhoods, after permission was received from the managers and directors. The flyers contained the researcher’s contact number to call for potential inquiry, see Appendix C.

The number of participants was reached to operationalize saturation in the study and was contingent on addressing: 1) the research purpose and aims; 2) the conceptual framework and theoretical position; and 3) limits to the scope of the study to avoid the saturation of not losing its potency and cohesion if the conceptualizations are stretched too widely (Saunders et al., 2017). Therefore, 31 participants were recruited to reach saturation which included the first three pilot interviews (Saunders et al., 2017).

The first three interviews were pilot interviews which was 10% of the intended goal of 30 participants to interview (McIntosh & Morse, 2015). The pilot interviews were needed to assure that the designed questions addressed the research purpose. Pilot studies assisted the researcher in further understanding herself as a researcher by identifying potential barriers of resistance to the audio recordings, or trust with the researcher’s agenda. Piloting not only can yield a description of the initial observations but the researcher’s ability to manage the research and the strengths of the genre for developing enticing research questions (Marshall & Rossman, 2011; McIntosh & Morse, 2015). The pilot interviews were included in all the interviews for data analysis, unless otherwise determined by the student primary investigator’s (SPI) dissertation committee, which was required by the Institutional Review Board (IRB) submission, where all the pilot interviews were included along with all the interviews for data analysis.

Overview of Information Needed

Four areas of information were needed to answer the research questions. These general areas are contextual, demographic, perceptual and theoretical information which exuded light on the identified gaps the researcher held for the study. It was important to note social determinants of health (SDoH) were needed in the descriptions address qualitative inquiry which have further perpetuated the poor health of African Americans. The specific relevancy and purpose of each area will be discussed as it relates to symptom management, quality of life and Critical Race Theory (CRT), (Bloomberg & Volpe, 2008).

Contextual Information

Contextual information for this research study discussed geographical location of participants during the study as well as cultural, social, and environmental issues which are essential to the data that was collected. According to the CRT, key characteristics of societal racialization were aimed specifically at the time of the study, or contemporary patterns of racial relations. This understanding was central to the focus of CRT scholarship of explaining racial phenomenon. It was important to know the significance of how social, historical and political forces are derived from racial stratification and how race is a social construct particularly with the current racial issues from COVID-19 and the increased racial tensions stemming from policing among African Americans and the rise of protests and “Black Lives Matter” in the U.S. (Ford & Airhihenbuwa, 2010; Ruiz et al., 2020; Desilver et al., 2020).

Also, amid the increased racial tensions surrounding the death of George Floyd while in custody of the Minneapolis police and the national reaction of protests was considered as the researcher recruited African American men (Desilver, et al., 2020). Racism was part of the daily dialog in the media surrounding the historical issues of racism and “Black Lives Matter” and was considered as it shaped the participants’ contextual views.

Investigation of the environment of where the participants lived, along with historical perspectives, aligns with the CRT tenet of the historical forces from racism. The organizational or institutional information regarding leaders, structure and systems was completed for the literature review of the historical and current contexts within the geographical area of where the study was conducted.

The context, circumstances, conditions, or situations of a person's life was considered as it informs their perspectives and influences behavior (Bloomberg & Volpe, 2008). The socioeconomic and geographical location of the participants was from low-income and subsidized housing and possibly homeless. The location, condition of the housing, surrounding environment or if the participant had housing, and available resources was important contextual information to consider as living conditions impacts a person's perception of their quality of life and health.

Important demographic contexts and perceptions of the participants included health care access, health insurance, transportation, food security and other supports and barriers within the communities of where participants reside. Demographics are both interpersonal and intrapersonal, which were important to consider as it provided additional context for the participants further informing the perceptions of their health. In addition, further collection of contextual data was evaluated during the study to assist the researcher in her understanding of the participants during the data collection and analysis phases (Bloomberg & Volpe, 2008). The information in this section along with other demographic information will be discussed next.

Demographic Information

Individual participant demographics provides information that can describe who the participants are within the study. Demographics of each participant contained historical background, education, personal information of age, marital status, monthly income, food security, health care access, and transportation. Demographic information further determines any underlying perceptions of the individual as well as any differences or similarities among the perceptions of the participants (Bloomberg & Volpe, 2008). For example, a specific demographic such as age impacted specific findings in the study (Bloomberg & Volpe, 2008). The demographic information was collected as part of the interview once the potential participant is found eligible and consent was received to participate in the study (See Appendix C; Eligibility and consent to participate in research study).

After collecting the demographic information from each participant, a table was created to organize the findings. Vertically, the pseudonym for each participant will be provided and the specific demographic data was listed horizontally illustrated in Table 6. Not all the demographic information is included in Table 7 but is an example of part of the table that assisted to organize demographic information.

Table 7. Participant Demographics Example

Participant (by pseudonym)	**Age**	**Heath care insurance and type**	**Type of Housing**	**Marital Status, partner or significant other**	**Level of education completed**	**Employed/ most recent employment**	**Chronic diseases and onset**	**Medications prescribed for chronic conditions**
Participant 1								
Participant 2								
Participant 3								
Participant 30								

Perceptual Information

Perceptual information gathered from the participants was the most critical and primary method of data collection in the qualitative research (Bloomberg and Volpe, 2008). The perceptual findings relied on interviews from each participant for the study. The interview questions provided a forum for participants to share his perceptions, understanding and experiences while living and managing chronic illness. The descriptions of the participants' experiences gave insight on how participants may have had a shift in attitude, mindset or experiences that influenced decisions they have made. Perceptual information is critical to CRT, considering how social structures, intersectionality, and racism is tightly woven in the social fibers of society and impacting participant perceptions. The perceptions of the participants for this study were entrenched in long-lived assumptions through his or her world view where racism is central to shaping these perceptions. (Ford & Airhihenuwa, 2010; Bloomberg & Volpe, 2008, pp. 65-94). The needed theoretical information will now be discussed.

Theoretical Information

Interpretive and theoretical frameworks further shaped the investigation, the three elements of worldviews, assumptions and frameworks frequently overlapped and supported each other. Interpretive communities, feminist theory, critical social theory, post-modern perspective theory, queer theory, disability theory, and critical race theory each have disparate literature and distinct issues that support interpretive views in offering perspectives to engage in all facets of qualitative investigation. Participants involved in interpretive projects, are underserved or marginalized due to race, gender, class, sexuality, or any intersectionality of them. The topics examined reflect problems or issues within circumstances that further disadvantage or underserve individuals, communities and populations, like racism or low socioeconomic status where unequal power relations and the outcomes result from these root problems that lead to premature morbidity and mortality (Graham et al., 2011).

Theoretical information starts with the epistemology of the researcher, which is from a critical social philosophy. As a nurse working within low-income communities of adults, class and racial issues has been a poignant concern for the researcher. Through ongoing interactions, observations and concerns of health inequities for a population that suffers from many comorbidities, the researcher has found a method to inquire about the social structures and racial constructs through in-depth interviews with the participants to provide a voice for them.

Critical Race Theory (CRT) has been a growing transdisciplinary, race-equity methodology since the 1980's and has its roots in legal studies and is grounded in social justice (Donnor & Ladson-Billings, 2018). The tenets within the CRT are purposeful to gain modern racial phenomenon, challenge racial hierarchies and increase the vocabulary of complicated racial concept (Delgado & Steffancic, 2017). According to Creswell (2007), the use of CRT in research upholds the investigator to spearhead racism and race in all aspects of the research and to tackle conventional worldviews and research work.

The theoretical information that was reviewed and synthesized from the literature review in Chapter two was through the support of Black essentialism and CRT. As the researcher has been reflexive throughout her PhD journey, where she has had increased awareness of her privileges and social positions within the U.S. society and within the context as a researcher and nurse educator, providing health care services to some of the communities she recruited participants from. This process has facilitated increased growth and understanding of the deeply embedded discrimination and racism within the American culture which continues to evolve and guide my philosophical lens, remaining race conscious, and aware of the power differentials between potential participants and myself as the primary student investigator for this study. Through a CRT lens along with her literature review, the researcher has provided evidence of issues among African American men's health and where further gaps exist within the management of chronic illness among this population.

The theoretical aspects of this study were guided using CRT which supported the methodology by providing a voice to persons of color which is in alignment with one of the tenets of CRT. This tenet of CRT provides a forum to hear from marginalized persons' perspectives and experiences, to help identify phenomenon within the population of African American men, which are of concern (Marshall and Rossman, 2011). By hearing the experiences of low-income African American men with complex health conditions through their voice and perspectives helped to produce counternarratives, to balance the hegemonic, dominant white culture representations of the experiences of African American men. This study increased the understanding of the health inequities and social injustices that minorities and low-income persons face and experience being Black in American (Delgado & Stefancic, 2017).

Other theories and concepts have been reviewed related to chronic illness, social determinants of health (SDoH), and the health inequities of marginalized populations, specifically African American men that has been evolving over time from racism. The disproportionate health outcomes among African American men from chronic disease is of great concern for the researcher and other stake holders from public and community health disciplines. The ongoing social injustices for African Americans within the U.S. have perpetuated poor health and health outcomes that have led to disproportionate, premature morbidity and mortality among African American men compared to their white counterparts.

My clinical background as a nurse, has been caring for patients with chronic illness for over two decades. My role as a community health nurse, with a specialty in hospice and palliative care, the concepts of symptom management, quality of life, short and long-term health planning were of interest to me particularly among low-income, African American men. In addition, the concepts of symptom management, quality of life, short and long-term health planning has not been studied among this population, through a critical race lens.

The literature review assessed how African Americans manage their chronic conditions with few studies critically examining how SDoH, inequalities, inequities, racism, discrimination, and other structural barriers have burdened African American men disproportionality than their white counterparts. The studies that considered structural barriers for African Americans were from either public health or other social science disciplines but none from nursing. Therefore, the experiences, perceptions and understanding of the concepts of symptom management, quality of life, short and long-term health planning of middle aged and older, low-income African American men with three or more chronic conditions were explored through individual interview (See Table 8; Overview of information needed), (Marshall & Rossman, 2011).

Table 8. Overview of Information Needed

Type of Information	What the Researcher Requires	Method to Attain Information
a. Contextual: To provide background & context	Historical background of population of African American men, economic status of geographical area where participants reside, segregated housing (both low-income and racially) within the communities of	Literature review and observation through researcher's experiences with population

	where the research will be conducted, consideration of disproportionate mass incarceration of African American men compared to all other races in the state of WI and is the highest in the state of WI, services available, leaderships and sight description,	
b. Demographic	Descriptive information of participants: for e.g., age, type of housing, health care access, income, support, and service support	Oral survey with participant
c. Perceptual	Participants' explanation and descriptions of their experiences at it relates to the phenomenon of interest.	Semi-structured interviews either virtually or by phone with participants
d. Theoretical	Researcher's critical race lens while remaining reflexive always throughout the entire research process. Ongoing literature review	Field notes, observations, collaboration and discussion with dissertation committee and clarification with participants with any questions by the researcher during or after the interviews. Analyzing, synthesizing literature regarding the phenomenon of interest.

Research Question # 1: How do African American men with three or more chronic diseases perceive and understand the chronicity and complexities of their health condition?	If African American men know about their diseases, how do they view and understand each one and the impacts of the multiple diseases on their health?	Interviews, historical and current context
Research Question # 2: How do African American men with three or more chronic diseases perceive and understand symptom management by practicing self-management and quality of life.	How do African American men with comorbidities know, understand, and manage their chronic conditions and symptoms? What does quality of life mean to African American men while living with comorbidities? What is the understanding of African American men of how their symptoms from their chronic health conditions can be managed? How do African American men relate symptom management to quality of life? Therefore, improve quality of life.	Interviews, historical and current context
Research Question 3: How do African American men with three or more chronic diseases perceive	Do African American men with 3 or more comorbidities think about their future health and if so, do they set any goals that are short or long	Interviews, historical and current context

and understand short- and long-term goals and advanced care planning as it relates to their health.	term? Do they know about advanced care planning and have they considered advanced care planning based on the seriousness and complexities of their health? Why or why not?	

Design

The research study utilized a qualitative approach with the primary data collection method of in-depth, semi-structured individual telephone interviews due to the pandemic of COVID-19. Individual, in-depth interviews where two or more people discussed a theme of mutual interest and knowledge are created (Marshall & Rossman, 2011). Important aspects to my role as the interviewer was the ability to convey the participant's views that are useful and valuable (Marshall and Rossman, 2011). In addition, I brought skills to the interview through preparation, anticipation of how I would be received and ethical issues that may have risen. Also, the ability or skill I had to ask questions or follow-up questions assisted to further investigate the participant's perceptions. These techniques were performed through open-ended elaborations, detailed elaborations, or open-ended questions, see Appendix D for interview questions (Marshall & Rossman, 2011).

With semi-structured interviews, interviewers have the freedom to diverge slightly from the interview script where open-ended questions are formulated to elicit unstructured responses to generate discussions (McIntosh & Morse, 2015). More importantly the exact phrasing of the questions was relayed equivalence of the meaning to all participants (McIntosh & Morse, 2015). Lastly, interviewers are expected to probe with each participant's response for further elaboration. The techniques of preparing for the interview as well as probing questions contributed to the study's replication and flexibility (McIntosh & Morse, 2015). The advantages and barriers to telephone or virtual interviews will be presented.

The advantages of phone and virtual interviews will be discussed first. Phone interviews with semi-structured interviews (SSI) include: 1) enhanced accessibility for populations that may be challenging to reach, like older adults or homeless individuals, 2) exclusive auditory communication or the absence of visual cues or preconceived ideas about the interviewer caused by their appearance, White interviewer interviewing African American men, which could impede the participants from fully expressing their perspectives; 3) phone interviews can encompass larger geographical areas; 4) are less costly in terms of labor and time, therefore more efficient; 5) are more feasible in a given time period versus a face-to-face interview; 6) increased interview and participant safety; 7) reduced distractions for participants from interviewer taking notes; 8) increased privacy, perceived anonymity; and 9) less intrusive and assists to mediate power differentials between interviewer and participant by negotiating interview times that best suit the participant, rescheduling, interrupting or ending the interview (McIntosh & Morse, 2015; Drabble et al., 2015).

The advantages of virtual interviews will now be discussed. A virtual face-to-face interview is more personable where rapport and trust can be established. It also allows for the interviewer to utilize non-verbal communication as collected data (Janghorban et al., 2014; Iacono et al., 2016). The other benefits are similar to phone interviews which include increased safety for both participant and interviewee, more control or power for the interviewee to end the interview at any time, and more efficient with resources and both virtual and phone interviews are necessary to keep participants and the interviewer safe from contracting COVID-19. Since the pandemic, in person restrictions were put in place to protect high risk individuals, those with chronic conditions, therefore phone interviews were mandated by the institutional review board (IRB) (Janghorban et al., 2014; Iacono et al., 2016). The disadvantages with phone and virtual interviews will be shared.

Participants who do not have access to a phone, internet, or computer wi. According to Irvine and colleagues, they found that phone interviews were shorter than face-to-face interviews (Irvine, 2011; Irvine et al., 2013). Yet, other studies found no differences in the length, type of responses or depth between in-person versus phone interviews (Sweet, 2002; Sturges & Hanrahan, 2004). Other concerns regarding phone interviews include challenges with establishing rapport with the participant, the inability to respond to visual cues, and potential loss of contextual data, such as observing the participant within his setting of home or work (Dabble et al., 2015; Novick, 2008).

The potential barrier of trust is a concern to all types of interviews. Trust is needed for intimate encounters where participants feel comfortable sharing detailed or private information. One practice the White, female researcher engaged in was reflexivity. She was cognizant of the mistrust among African Americans with the U.S. health care system and from years of historical traumas to participants like African American men (Adebayo et al., 2019; Beach et al., 2011; Hausmann et al., 2011). The benefits of individual interviews for this researcher were her familiarity with the current communities she recruited from. She did not know all the potential participants but with her background and providing care to this population, over several years, has been able to build some trust with the aggregate.

Data Collection & Procedures

Inclusion Criteria Assessment

Once a potential participant inquiry was received by me regarding the study, by phone or email, found on the research flyer, see Appendix C, the researcher assessed eligibility criteria via the inclusion criteria, see Appendix D. The researcher contacted the potential participant to schedule a convenient time for the potential participant, where each participant was further assessed for inclusion criteria to participate in the study. Inclusion criteria assessment was completed via phone conversation by the researcher where each participant's capacity and ability to participate in the study was determined. Competency or capacity of the individual, potential participant, was important to consider his decision making ability to understand relevant information, to reason the given information, ability to communicate choice and ability to appreciate the nature of the situation along with the consequences (Kadam, 2017).

The inclusion criteria assessment by the researcher inquired whether the participant made his own health care decisions, spoke and understood English, was 40 years of age or older and identified as an African or Black American male his entire life. The remaining inclusion criteria questions captured the individual to self-identify their chronic diseases, which was at least three or more conditions either by sharing the medications he takes or known diagnoses and reported being low-income by disclosing annual income if they were comfortable. Based on my assessment of the participant and his responses, I informed the potential participant if he met inclusion criteria (See Appendix D). After inclusion criteria was met, I negotiated a time that was most convenient for the participant within 24 hours of the initial contact.

Consent

The interview meeting with the potential participant, via phone, started by receiving consent to audio record, then a review of the study's purpose, and finally a thorough discussion of the study consent (See Appendix G). The utmost importance and efforts of mine was to assure a meaningful and informed consent by each participant (Kadam, 2017). Informed consent was established through a complete, meaningful, and valid consent process where the potential research participant must receive and comprehend information appropriately and make an autonomous decision. According to Kadam, (2017), a complete, meaningful, and valid consent process included all four criteria areas be met: 1) information disclosure; 2) comprehension; 3) competence; and 4) voluntariness were all effectively met (Kadam, 2017).

A verbal consent was in lieu of a written consent since the study was performed by phone due to the current restrictions of no in person interviews through University of Wisconsin-Milwaukee Institutional Review Board (UWM-IRB), as of July 2020, due to the COVID-19 pandemic. Written consents were impractical or burdensome for participants who participated in the phone interview, hence I received an audio recorded verbal consent to participate and have completed the waiver for documented consent through the UWM-IRB.

The consent consisted of two parts, part one as the research description and part two which is the participant's rights (See Appendix G). Part, one included the description of the research interview, which entailed the length of the interview of one to two hours, permission from the participant to be audio recorded then transcribed, to capture and maintain an accurate record of the discussion between the participant and me. I assured each participant that his name was not used on any of the data that was collected, but rather a pseudonym (Bloomberg & Volpe, 2008).

At the interview meeting, I read and reviewed the consent with the participant and answer any questions the participant may have before he verbally agreed to the consent to participate in the study. This process assured that the participant had full understanding of the study and had verbally consented to participating in the study.

Part 1 of Consent

Part, one discussed the risks and benefits by the participant's contribution to the study to improve the understanding nurses and health care providers to better support African American men with complex chronic conditions. Each participant will receive $30.00 cash as a token of appreciation for participating. The payment was given after each interview was completed even if the interview is not completed, due to the participant opting to discontinue. Data storage to protect confidentiality will be discussed.

The participant understood that under no circumstances would his name be identified, and he would remain anonymous throughout the course of the research study or in any publication thereafter. The participant knew all efforts taken to assure the information he provided would be treated with strict confidentiality and then securely stored by me in my electronic files where I have the only password and access. The results of how the research will be utilized will now be shared (Bloomberg & Volpe, 2008, pp. 65-94).

I discussed how the research study was in partial fulfillment of her Doctoral Degree in Nursing from University of Wisconsin-Milwaukee. Then results from the dissertation will be published as a dissertation along with manuscripts to share the results of the study. In addition, the information from the study was used and will be continued to be used to for educational purposes in professional presentations, or for policy changes and further research. Part two of the consent will now be discussed (Bloomberg & Volpe, 2008).

Part 2 of the Consent

Part two of the consent included the participant's rights throughout the study. This included how the participant had full knowledge of the study by hearing it read to them, the opportunity to discuss the research description and then had the opportunity to ask questions regarding the purposes and procedures about the study. Each participant also had full understanding that his participation was voluntary and that he could refuse to participate or withdraw from participation at any time without jeopardy to future medical care or other entitlements he may be eligible, such as services from Edgewood College nursing students. The participant also understood that at any time during the study, he could withdraw (Bloomberg & Volpe, 2008).

The participant was given the researcher's phone number and email if he had any further questions regarding the study or his participation which was provided in the consent. The participant was also given the researcher's faculty advisor's phone number if he has questions, which is provided in the consent. The participant had access to the phone number of the Institutional Board Review at the University of Wisconsin-Milwaukee, provided in the consent, should he have had concerns or comments about the conduct of the research. Lastly, I informed the participant that the interviews would be conducted in a private area within her location, without any disturbances. Each participant was assured that audio recording is part of the research where only I, the primary researcher and members of her dissertation team would have access to written and recorded materials (Bloomberg & Volpe, 2008).

Semi-structured Interview

The interview began with opening questions from the instruments that were designed by the researcher, (see Appendix F). Each interview was based on how participants responded and understood questions. I remained flexible and accommodating during the interviews to either clarify or reword to assure that each participant understood the question while I continued to be very aware and reflexive of my White privilege and remain race conscious as I interacted with each Black American man I interviewed. I also utilized therapeutic communication of silence, clarification, validation while being aware of the participant's comfort level during the interview as best as I could without being physically visible to the participant and relying on verbal cues throughout the interview.

If the participant became upset or distraught in any way, I paused the audio recording and interview and provided emotional support. Based on the participant's preference, the interview continued as no participants wanted to terminate the interview. Pauses and emotional supported was needed for men who were going through challenging circumstances.

After most of the questions were answered and the interviewer asked any remaining clarification questions or if the participant had any questions before ending the call. I did not need to contact the participants after listening to the audio recording or rereading the notes I had taken from the interview. I informed the participant that all my findings from the interviews would be transcribed verbatim, analyzed, and shared with my dissertation team. Lastly, I informed each participant that I had a goal to publish the results in health-related journals to provide awareness and education to other health care professionals and nurses.

I concluded by offering to contact the participant with the results of the study and any publications of the work. Then I arranged how to give the participant his $30.00 as her token of appreciation for participating in the study and delivered it to the participant's location. I expressed my gratitude for each participant's time and for sharing his perspectives and experiences. Ethical considerations for the research study will now be discussed.

Ethical Issues to Consider

The most ethical concern to date involves the vulnerable population that was examined amidst the COVID-19 pandemic and how marginalized populations are disproportionately impacted (CDC, 2020). It was important to consider how questions or concerns regarding the pandemic would arise during the interviews. Therefore, I consulted with my dissertation committee on how to best manage these concerns or if some of the interview questions needed to be amended to capture some of this data. Phone interviews versus in person interviews will be discussed.

Phone interviews for qualitative research are methodically not advised according to the literature. This is largely due to the social encounter not achieving rapport and the loss of nonverbal or loss of visual cues to aid in communication which convey more subtle layers of meaning (Irvine, 2010). Empirical evidence concludes that the qualitative process of face-to-face versus phone interviewing has fairly small differences regarding the data results, which are based on impressionistic accounts rather than systematic mode comparisons (Irvine, 2010; Holt, 2010; Novick, 2008).

Critically viewing the ethical challenges of communication between the participant and me was important to consider. Through ongoing reflexivity, I was cognizant of the vocabulary that was spoken, heard, and written while adhering to the principles of respect, nonmaleficence, beneficence, and justice in a way that is mutually beneficial to the participant and researcher (Aluwihare-Samaranayake, 2012). I was diligent to enable the humane transformation of multiple interpretations of the participant’s life and community experiences, whereby re-inventing power rather than transform, take or translate power, according to Freire (Aluwihare-Samaranayake, 2012).

By creating an emancipatory strategy with dialogue, reflexive questioning and listening, can lead to a shared critical consciousness between the researcher and participant. The emancipatory strategy while also remaining true to CRT, can ethically lead to representing the reality of a person's experiences in a manner to avoid leaving that person feeling oppressed, disempowered, and vulnerable to emotional stress (Aluwihare-Samaranayake, 2012).

Respectfully addressing each person, I treated all participants as autonomous agents. This ethical principle involved access to participants, confidentiality, and informed consent which prevented the exploitation of participants. Central to individual respect and equity was the goal in how the participants were recruited. Flyers were made and posted in all the communal areas of where persons were recruited from which assured equal opportunity for all (Greaney et al., 2012).

Awareness of presence during interviews was important so as not to show bias, judgement, or discrimination and to treat all participants equally. I was diligent throughout the research process utilizing ongoing field notes throughout the entire research process to assist with minimized biases along with the ongoing practice of reflection/reflexivity. I was steadfast to reflect on my positionality, while remaining race conscious by the deep awareness of my racial position, and awareness of racial stratification processes throughout the study.

Since I am familiar with most of the communities of interest, established trust among members of the community could have recreated biases from my perspective. Therefore, it was imperative for me to utilize reflexivity during the entire research process. Since my background and position impacts what I choose to investigate there are several points of concern to avoid: 1) the angle of investigation, 2) the methods judged as most adequate for the purpose, 3) the findings found to be most appropriate and the framing and communication of findings, and 4) risk of bias or skewedness are possible in all research and most undesirable (Crabtree, 2008). Therefore, ongoing reflection and reflexivity was necessary and advisement from my committee was upheld throughout the study. Trustworthiness will now be presented regarding the study.

Trustworthiness

Trustworthiness was a method used to persuade readers that the research findings are worthy of attention to put the knowledge created into practice (Nowell et al., 2017). The concept of trustworthiness was further refined for qualitative research to include: 1) credibility; 2) transferability; 3) dependability; 4) confirmability; 5) audit trails; and 6) reflexibility. I will discuss these concepts further as she applies it specifically within her data analysis (Nowell et al, 2017).

I diligently maintained field notes throughout the study. This practice assured ongoing reflexivity/reflection and to further limit any biases by me that should arise. The practice of reflexivity occurred with the support of my dissertation committee to assure complementary and divergent perspectives of a study's situation. These actions provided context which the researchers' values, beliefs, and assumptions, which often can be hidden, can be revealed, and contested (Crabtree, 2008).

Another method of trustworthiness is clarification. I clarified responses by reviewing the participants' responses to assure accuracy of what each participant shared. This was accomplished after each individual interview, after transcription and analysis to avoid confusion or misunderstanding of the gathered data. After I performed the first three interviews as pilot studies which assisted with my ability to be sophisticated and experienced to explore the verbally shared narratives by participants, where it further enhanced overall responses and breath of data collection (Ritchie et al., 2014)

Data Analysis and Synthesis

Data analysis and synthesis started during and after each interview and observation (Merriam & Tisdell, 2016). To accomplish this, I immersed myself in the data by identifying insights. This process further directed me to refine interview questions. Further recruitment for interviews were completed after the researcher felt she reached saturation then a more intense analysis began (Butina, 2015).

Post data collection and after each interview, the written and recorded information was secured in a locked compartment that I only had access to in my private home office. The data analysis and synthesis were transcribed, while maintaining anonymity of each participant into a word document which was kept in a locked computer where I only had access to. The data was managed through the support of the conceptual frameworks then categorize the raw data within the constructs of the conceptual framework and assigned initial codes to pertinent quotes from the participants. The iterative process of open coding led to ongoing refinement of the final coding schema (Bloomberg & Volpe, 2008).

Identifying significant patterns and developing a framework for communicating the essence of what the data revealed was ongoing. After clarification of the data and transcription of the data, the recordings will be erased or destroyed or within two-four years of collection. The digital data is stored in secure electronic devises in several areas where only the researcher can access the information. All demographic paperwork will remain locked and secure on designated electronic devices.

Implications & Contributions

Implications and contributions gained from this study will be discussed. First, as the focus of chronic illness management in public/community health and primary care, the profession of nursing can spearhead how structural racism and classism continues to disproportionately impact poor health outcomes among African/Black American men. Second, this study showed how the participants manage their chronic conditions while living with the barriers of racism and SDoH. Third, the participants were given a forum and voice as they shared their lived experiences with complex chronic disease. Lastly, the findings demonstrated need for more critical race approaches to theory, methods in practice and more advocacy and political action for change with African/Black American health.

Nurses have a unique role within communities where they can build trust with community members by their presence, guidance, education, and advocacy for those who lack equality and equity in health. Nursing provided an innovative approach by critically examining middle-aged and older, low-income Black men with comorbidities in how they manage their health and symptoms by addressing forces (racism, classism, and structural racism) that further disadvantages these populations. Lastly, action is needed on many levels by nurses to educate, advocate and push for policy change to address how barriers among low-income, African/Black American men with complex chronic disease impacts their health outcomes and quality of life where further understanding and support has increased but more is needed.

By providing a voice and empowering African/Black American men, who are low-income and suffer disproportionately from many social and structural issues of racism and social determinants of health, can add to the gap in nursing science in many ways. First, using critical race theory is innovative in nursing practice to address health issues that have essentially been viewed through a European existentialism view within the U.S. White dominant society. Second, interviewing only African/Black American men, who are low-income and have three or more complex chronic conditions within the discipline of nursing has not been done and provided a voice to these men through an emancipatory approach.

The disseminations of findings occurred on many platforms. I shared in my writing the emotional nature of the project, my passion, the purpose, political aspects and concerns that was reflected in first person. The call to action is the ethical responsibility in using critical race theory in research. Verbal consent was needed in lieu of a written consent since the study was performed by phone due to the current restrictions of no in person interviews through University of Wisconsin-Milwaukee Institutional Review Board, as of July 2020, due to the COVID-19 pandemic. Written consents were impractical or burdensome for participants who participated in the phone interview, therefore, I received a recorded verbal consent to participate and have completed the waiver for documented consent through the UWM-IRB. I have addressed the outcomes in chapter four and implications in chapter five.

Limitations

Limitations are inevitable with any research therefore the researcher was prepared with potential barriers through initiative-taking and therefore less problematic. The methodological limitations included maintaining confidentiality among the participants since the communities lie within close range of each other. Therefore, I emphasized the importance of confidentiality among all participants and remained cognizant and unbiased with recruitment, during the interviews and when sharing the results, since I was familiar with the communities that were studied.

A pilot study of three interviews assisted with potential issues with questions that could have limited responses as well as provided the me with an opportunity to amend questions for more clarity for participants and to best understand the experiences of the participants as it relates to the purpose of the study. The pilot study increased my ability to interview participants, increase confidence, and assure clarity with the questions.

Participant data provided adequate saturation for the trustworthiness of the study. A strategy that assured saturation was to increase the number of neighborhoods or low-income areas which increased anonymity to improve confidentiality for all participants.

Limitations from a theoretical perspective was the commitment to reflexivity and communication. First, I practiced ongoing reflexivity and reflection by journaling my perceptions, insights, and role as a middle-class, privileged White female throughout the dissertation process and I continue to remain race consciousness, one of the tenets from CRT. The goal of reflecting was accomplished by documenting at least three times a week as well as before and after each interview.

Second, I was diligent to share my struggles or concerns with my dissertation committee by communicating with my major professor any concerns or questions as well as collaborating with my dissertation committee for guidance and recommendations. Remaining steadfast to these two goals was essential for the success and progression of the study (Ormston, et al., 2014).

The results of the research will be published in manuscripts or other publications regarding perspectives, values, positions, and beliefs that are valuable and essential of the researcher. Through the practice of reflexivity, since I chose the manuscript dissertation option. Sharing these thoughts unveiled preconceptions, beliefs or assumptions that may have interfered with the results or outcomes of the study, leading to some limitations from biases (Crabtree, 2008).

Disseminating Findings

Chapter three described how the study led to further comprehension regarding the purpose and questions of this qualitative inquiry. Based on the literature review, the gaps in African/Black American men's health as it related to living with complex chronic health conditions, symptom management and quality of life was best answered through a qualitative approach. The provided contextual, theoretical, demographic, and perceptual information gained from this study provides new insights regarding African American men with complex chronic conditions to improve health outcomes, symptom management and improved quality of life.

The science of nursing has not utilized many emancipatory approaches within research by specifically using CRT among African American men. The approach to the study was innovative to healthcare and the profession of nursing. The use of interviews provided a voice and perspective in how racism and classism helped to address racial health disparities among for African/Black American men. Utilizing a method that provided voice to marginalized populations remained true to one of the tenets of CRT were providing voice and hearing the experiences of African and Black American men with complex comorbidities was overdue. I provided fidelity to CRT in this study by practicing intentional reflexivity, race consciousness and humility through reflection of my social position regarding class and ethnicity/race while I explored the experiences of low-income African American men with complex chronic conditions and how they manage their health.

The dissemination and action based on the research is of utmost concern with the use of CRT. The action of advocacy, by sharing the voices of African American men living with multiple chronic conditions, and policy changes, to improve health disparities among African American men is planned. I contributed to the discipline of nursing to support this population with complex chronic conditions. In addition, the role of community nursing through relationship building of trust, presence, collaboration and as a liaison between inpatient, primary care, community, and population health can assist at decreasing health disparities among African American men.

The study supports how nurses need to further understand how to care for this population with complex chronic disease and assure symptom management, quality of life, and advanced care planning to this population’s short and long-term healthcare goals. The result of this study demands new directions in a critical race approach among marginalized populations with complex health conditions through theory development and ensure more emancipatory nursing theories. Most importantly, the goal of policy change to improve African American health and decrease health disparities, particularly among African American men’s health.

Chapter 4

One of Three Manuscripts Entitled:

Black Men's Resiliency and Persistence to Grow Old: A Midwest Qualitative Study

Abstract

As Black American men continue to experience the highest premature morbidity and mortality, few studies have centered on the intersection of class (low-income) and race (middle-aged and older Black men) with multiple morbidity in the Midwest region of the United States from a critical race theory approach. Middle-aged Black men have a 31% higher death rate than their White counterparts. A qualitative study was conducted by a community health nurse in the spring of 2021 in a metropolitan city. Thirty-one, low-income Black American men were interviewed using critical race theory and focused on their understanding and perceptions of their complex comorbidities, symptom management for quality of life, and short and long-term health planning. Thematic analysis and reflexivity were utilized for the dissemination of the men's narrative as they shared their journeys with their resiliency by resisting racism but persisting to grow old. Two major themes were identified through analysis of participant narratives: resiliency to resist oppression, and racism and persistence for quality of life. These themes were developed from narratives of participants who identified as low-income Black men with complex co-morbidities. How they understood their health, managed their symptoms for quality of life, and used short and long-term health planning were analyzed. Community health nursing has an important role, with a multidisciplinary approach, to build relationships and trust among this population for higher quality of life and to support this population toward the opportunity to age and to grow old. Through further community participative research, advocacy through a collaborative disciplinary approach and policy action, addressing and acting against racism as the root of Black men's health disparities can be eliminated.

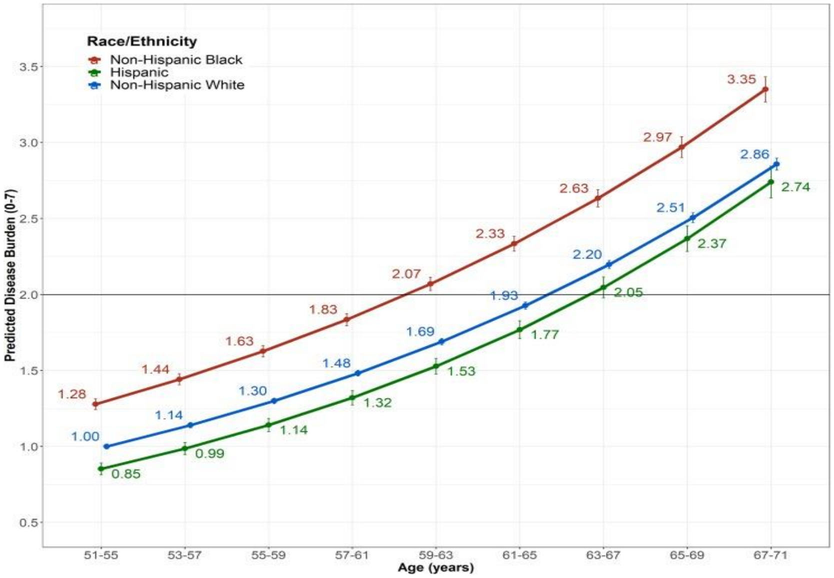
Keywords: Racial disparities, resistance, resiliency, symptom management, quality of life, short- and long-term health plan, critical race theory

Black American men’s health has been a growing concern among policymakers, civic leaders, public and community health providers as the disparities in health outcomes continue to grow (Wade & Rochlen, 2012). Statistical reports along with recent studies have shown that Black Americans have earlier onsets of chronic disease through a lifetime of exposures consisting of direct, indirect racism to structural issues embedded within the U.S. culture and societies that are based on racial discrimination (Barr, 2014; Cunningham et al., 2017; Gee & Ford, 2011; Ford & Airhihenbuwa, 2010a; Williams, 2010; Glymour et al., 2014; Krieger, 2014). Persons who report experiencing racism exhibit worse health and increased morbidity and mortality (Barr, 2014; Gee & Ford, 2011; Ford & Airhihenbuwa, 2010b; Williams, 2010).

U.S. historical racial traumas of slavery to ongoing implicit and explicit biases, and inequities in opportunities have further perpetuated poor health and quality of life, particularly for Black Americans. These are related to 1) security with socioeconomic status; 2) quality of living conditions; 3) choice of geographical areas to live; 4) quality of education; 5) injustices in the criminal system; 6) quality and timely health care interventions and 7) mistrust of the health care system (Alexander, 2012; Adebayo et al., 2019; Barr, 2014; Thorpe et al., 2016; Kwate, 2017; Nellis, 2016; Schnitter et al, 2011; Song et al., 2012).

In 2015, Black Americans in the age range of 50-64 years of age, had significantly more chronic illnesses per person and a death rate of 31% higher than Whites in the same age group (Chen et al., 2014; Cunningham, et al., 2017). Most middle-aged adults live with at least one chronic illness but persons of color and/or living in low-income have more than one chronic condition by midlife (Quinones et al., 2019). A longitudinal study examined the racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults and Black Americans start with an earlier burden of chronic disease and develop multimorbidity at an earlier age than Caucasians (See Figure 1., Quinones et al., 2019).

Figure 1. Non-Hispanic Black, non-Hispanic white, and Hispanic trajectories of chronic disease accumulation over time, HRS 1998–2014 (Quinones et al., 2019).



Earlier onsets of multiple morbidity and premature deaths are the highest among middle-aged Black Americans in the U.S. with most deaths occurring from chronic conditions, with HIV being the leading cause of death followed by cerebral vascular disease, diabetes, cancer, and heart disease, which all occur at higher rates among low-income populations (Cunningham et al., 2017). Research on these topics more recently has been addressing specific diseases like type 2 diabetes and heart disease, which are both prevalent among Black Americans, but few qualitative studies have addressed multimorbidity, the intersections of race/ethnicity and class from a critical approach in community health nursing. Therefore, this study builds on the literature and gaps of middle aged and older, low-income, Black American men with complex health conditions from a critical race approach. Acknowledging and understanding how racism is embedded in the U.S. and personally impacts the participants' quality of life, symptom management and ability to age and dictate their end-of-life wishes is a human right and socially just. Nurses must take a stand against these social injustices and be leaders of antiracist actions for Black American men. Critical race theory is a critical social theory that was chosen to guide the research study and will be discussed.

Theoretical Context

The study utilizes critical race theory (CRT), a critical social theory, which was developed in the 1980's by scholars of color from the legal academy. The origination of CRT by its creators sought to critically critique the operational behavior of the law. Scholars have since found that the U.S prides itself as post-racial (from Freedom Movement) yet grave disparities have persisted not only within the operations of the law, but permeate structurally and socially as inequality, inequity, and racism, all of which are cultivated and maintained by the White dominant culture of power, (See Table 1 for the tenets of CRT (Delgado & Stefancic, 2017).

Table 1. Critical Race Theory Tenets and Descriptions

Basic Tenets of Critical Race Theory	Description of Tenets
1. Racism is ordinary	Racism is difficult to address or cure because it is not acknowledged. Concept of color-blind or formal concepts of equality that remedies only the most blatant forms of discrimination.
2. Interest convergence or material determinism	Racism advances the interests of both white elites, materially, and working-class, psychologically, therefore large segments of society have little incentive to eradicate it.
3. Race is a social construct	Race and races are products of social relations and thought, where society frequently chooses to ignore these scientific truths and gives pseudo-permanent characteristics.
4. Differential racialization & its consequences	Dominant society racializes different minority groups at different times in response to changing needs, such as labor market or with stereotypes and images of various minority groups.
5. Intersectionality & anti-essentialism	No individual has a single, unitary identity.

6. Unique voice of color	Minority status brings with it a presumed competence to speak about race and racism to inform their white counterparts.

Adapted from Delgado & Stefancic (2017).

CRT theorists further lament that as racism continues to crowd the U.S. institutional structures, intersecting forces of oppression further builds upon racism creating negative outcomes to racialized populations. The framework of CRT supports deep contextual analyses at several intersections of a person's life. CRT analysis often triangulates contemporary facts against historical facts to gain understanding of findings. Triangulations are best captured through narrative data or the stories of the affected that gives credence to the framework, hence CRT is not only a theory but an interpretivist methodology for many social sciences (Williams et al., 2020).

CRT was used as an analytical tool to contextualize the narratives of the participants. Since all the participants identify as Black men, they therefore correspond to basic tenets of being marginalized by race, class, gender/sex, ablism, among other factors. CRT provides a unique ability to contextualize the men's narratives within a perspective closest to their lived reality given the history of exclusion and racism that Black Americans, particularly the unique pressures that Black men have had to face for centuries (Williams, 2020). Lastly, Christian et al., (2020) suggests four steps to the empirical application of CRT analysis in social science research: 1) understanding that social science is not value neutral; 2) using CRT to inform research methodology and design; 3) investigating racism at multiple levels of analysis; and 4) analysis and empirical data should reveal the relational aspects to racism. Next, the historical and current context of Black American men as it relates to distrust within health care institutions, uniqueness of Black masculinity and disparities of incarceration among Black men are necessary to understand the contemporary context or the narratives of the participants from this study regarding their health when analyzing from a critical race approach.

Historical Context

Distrust within Health Care Institutions

The significant institutional distrust among African Americans stems from the many racial injustices and ethical violations conducted in research, medical and public health entities within U.S. history. One of the most frequently cited violations influencing institutional distrust in health care among African Americans was the study conducted in Tuskegee, Alabama for forty years (1932-1972) where effective treatment for over 600 African American men with syphilis was deliberately withheld (Best et al., 2021). This alarming ethics violation demonstrated untrustworthiness in U.S. medical, research, and public health. While the U.S. syphilis study remains relevant among African American's institutional distrust, overlapping and intersecting violations of injustices, like centuries of slavery, occurred long before and after the syphilis study. Well-documented evidence exists with the negative association between institutional distrust and lack of utilization of health care especially among low socioeconomic populations and African Americans. Lastly, there are other factors that impact distrust among marginalized populations that include individualized experiences, collective experiences (Tuskegee experiment) and evaluation of trustworthiness among experts (Best et al., 2021).

Contextualizing Black Masculinity

Grounding Black masculinity for this study is needed to further understand the participants' experiences regarding their health in middle-age and older within a racial, cultural, and systems-based context (Williams et al., 2020). The development of Black masculinity in the U.S. is essentialized within oppressive and repressive contexts that originated from colonialism further suppressing Black masculinity as the Middle Passage disconnected the Black male from duties as protector of his family. Overtime, Black males were coercively socialized beneath Eurocentric masculinity, which is not inherently suitable for the African way of existence. Therefore, it is inevitable that the Black male will have conflict about his role as he does not fit into the Eurocentric masculinity mold within a society that has strategized to keep him out (Williams et al., 2020). The Black male's frustration regarding his status within the U.S. society can lead to physiological, psychological, and social abnormalities further leading to implications on Black men's lives and their families. Although enslavement has ended, other social issues for Black men continue producing gendered outcomes like Jim Crow and slavery, where frustration, oppression can lead to antisocial and aggressive behavior, further increasing the risks of encounters with the criminal justice system.

Contextualizing Racism against Black Men within Criminal Justice System

The U.S. incarceration rates is the highest compared to any other country in the world and one out of every twenty persons will serve time incarcerated at some point in his life. Persons of color have an even higher possibility of incarceration, with one out of three Black Americans spending time incarcerated. In fact, the state where the study was conducted has the highest Black-White disparity of incarceration in either jails or prisons (Macarow, 2015). Incarceration has become a pendulum where Black masculinity is worsened or even weaponized to further marginalize Black males, leading to increased health implications in many contexts (Williams et al., 2020).

Contextualizing Location of the Study

The location of the study occurred in a Midwest city that is close to Minneapolis and Chicago. According to the most recent American Community Survey from 2022, there are 360, 526 or 6.2% of Black Americans residing in the state (Kolmar, 2022). The county also has the lowest ratio of patients to doctors (770 patients to 1 PCP), and (220 patients:1 providers) including mental health providers in the state of the study. Within this county there are also abundant social programs to support those in need of additional resources (County Health Rankings, 2023). The county where the study was conducted has only 4.63% of Black residents compared to 78.7% of White residents (DATAUSA, n.d.). Participants were recruited from independent living low-income and public housing apartment buildings, and two community centers that provide support and services for low-income marginalized populations and those experiencing homelessness. The surrounding areas have three grocery stores ranging from one to four miles of these buildings. There are several fast-food restaurants, convenience stores, bars and liquor stores. Rates of incarceration of Black residents will be discussed next.

A report from 2021 in the county where the study took place found the rate of incarceration for Black residents is more than twice the national incarceration rate (Nijhawan, 2021). The report also found that the arrest rate for Black residents in the county was eleven times higher than for White residents and about 10% of Black residents are arrested every year compared to 1% for any other race or ethnic group. In addition, the current distribution of the jail population is identical to the arrest distribution demonstrating the primary source of the disparity occurs at the arrest point. Socioeconomic status is often the culprit for arrests and subsequent interactions with police, where bias in the arrest is race related (Nijhawan, 2021). In 2018, where the study was conducted, the largest racial poverty gap of 23 percent points. The national data from 2018 indicated that 22% of Black residents were living in poverty compared to 9% of their White counterparts, a gap of 13 percentage points (Hernández Kent, 2020).

Methods

The purpose of this qualitative study was to explore low-income, middle-aged (forty years and older) Black American men with three or more chronic diseases regarding how they perceived and understood: 1) the chronicity and complexities of their health condition; 2) symptom management for quality of life (QoL); and 3) short and long-term health planning and goals. After receiving approval from two institutional review boards (IRB) related to the study, participants were randomly selected after inquiring about the study through advertised flyers placed in community settings in an urban Midwest city from mid-March 2021 through mid-May 2021. After inclusion criteria were met for each potential participant, the interviews were scheduled within twenty-four hours of the interview which was convenient for the participant.

After meeting inclusion criteria, thirty-one men were individually interviewed by phone. Verbal permission for each interview was received and recorded on the audio recorder. After the completion of each interview, the researcher assessed the quality of the recorded interview to assure that it was clear to understand. No further follow-up after each interview was necessary as each recording was an acceptable quality to transcribe. Once the quality of the recorded interview was assured, an appreciation gift of $30.00 and any community resources the participant requested were given to each participant. Due to the mandatory mask mandate that was still in effect, the researcher delivered the gift and education materials to the participant in an envelope and folder with a mask on during daytime hours and maintained each interaction to ten or less minutes.

Analysis

In addition to using CRT, I was also informed by Braun and Clark's (2022) reflexive thematic analysis using both deductive and inductive methods from the narrative data. Much of the data was analyzed through an interpretative approach to disseminate underlying ideas, experiences, and concepts. I have been practicing deep reflection and reflexivity regarding her positionality two years prior to the study as a White middle-aged, middle class, educated, seasoned community nurse to increase her understanding and positionality in the U.S. and to be true to the tenets of the CRT. Her reflexive journey will be life-long and continued throughout her studies. Data analysis will be discussed next.

I began data analysis by familiarizing myself with the data, starting with the first contact of each participant on the initial phone call and at the end of each interview. Field notes were taken throughout the entire data collection process. Each interview was manually transcribed into a word document and saved on a personal and secure computer device. Each participant was assigned a synonym name and all personal identifiers were removed to maintain the confidentiality and privacy of each participant. The researcher transcribed all the audio interviews into word documents with each transcribed interview ranging in page length from 15-35 pages.

Deductive analysis started initially as the researcher color-coded concepts from the conceptual framework including: 1) orange: symptom management, which included disease management; 2) yellow: understanding and perception of their diseases, including chronicity and complexity of their health conditions; 3) green: quality of life; 4) pink: short term health goals; and 5) blue: long term health goals. The highlighted areas included either sentences or phrases developing ideas to describe the content. All the data were then collated into groups or codes which were identified by the idea or codes. The ideas or codes provided a condensed overview of the common meanings and main points that recurred throughout the data.

After structuring findings into the conceptual framework, deep reflection, reflexivity, and further inductive data analysis was grounded in the theoretical framework, CRT, which was consistent with the lived experiences of the participants. CRT served as a methodological tool to assist the researcher with the dissemination of the participant's journey's regarding their health from middle to older adulthood. CRT at its base demanded the researcher, the user, to fully assess how racism on many levels deleteriously affect marginalized persons. As Black men endure some of the harshest outcomes with race as the root determinant and the significance race, particularly Blackness, plays in the U.S. institutions and society, CRT was appropriate to utilize in this study. Therefore, after deeper reflective analysis, two main themes were identified further demonstrating the significant community and public health implications for the men of this study. The overall goal of the qualitative study was to explore how Black men understand and perceive their complex health conditions, manage their symptoms for quality of life and their short- and long-term health planning and goals (Williams et al., 2020).

Results

The study included thirty-one men, all who self-identified as Black or African American with most of the participants identifying as Black, which is therefore used to identify the men. The mean age was 56.5 years (ranging from 44-70). All participants identified as low-income and if they were comfortable reporting, live well below the poverty level (annual income of <$12,000). All the men shared they had health insurance with the majority using Medicaid and two participants were U.S. Service Veterans who had insurance through the military. All the participants self-identified a minimum of three chronic health conditions from prior diagnostics from health care providers and most were able to identify some or all the medications they were taking to manage their diseases. Several men were either homeless or in transitional housing post incarceration, with most of the men living in low-income or public housing apartments (See Table 10. Descriptions of the Participants N=31).

Table 10. Descriptions of the Participants (N=31)

Demographics	**% (n)**
Sexual identity	
Heterosexual	97% (30)
Homosexual	3% (1)
Education	
Less than a high school education	48% (15)
Completed GED or some college	42% (13)
Completed GED or some college while incarcerated	39% (12)
Graduated from high school	6% (2)
Marital Status	
Single	68% (21)
Married	3% (1)
Divorced	10% (3)
Separated	6% (2)
Widow	10% (3)
Partner	10% (3)
Fiancé	6% (2)

Most Common Chronic conditions reported	
Hypertension	74% (23)
Chronic pain	71% (22)
Anxiety/Depression/Bipolar	55% (17)
Hyperlipidemia	52% (16)
Substance disorder	48% (15)
Mental illness (schizophrenia, PTSD, Dissociative Disorder)	30% (9)
Diabetes Type 2	35% (11)
Chronic Obstructive Pulmonary Disease (COPD)	26% (8)
Heart disease	19% (6)
Chronic kidney disease	19% (6)
Number of chronic health conditions reported	
Four or more conditions	97% (30)
Nine or more conditions	13% (4)
History of incarceration (not a question asked)	39% (12)
Current employment	
On disability	71% (22)
Unemployed	29% (9)

Housing	
Public or low-income housing	71% (22)
Transitional housing	10% (3)
Homeless	19% (6)
Health care factors	
Has primary care provider	13% (4)
Does not have primary care provider	87% (27)
Health insurance	
Medicaid and Medicare	35% (11)
Medicaid	48% (15)
Only Medicare-6%	6% (3)
Only benefits through Veteran’s Administration-3%	3% (1)
Both Medicaid and Veteran’s Administration-3%	3% (1)
Reported No insurance	3% (1)
Has Power of Attorney for Health Care (POAHC) in place	35% (11)
Requested more information regarding POAHC	42% (13)
Full code or wants cardiopulmonary resuscitation	95% (29)
No code or Do not resuscitate	6% (2)

Two themes were identified from the narratives that the men shared regarding their experiences of living with complex morbidity, managing their symptoms for quality of life and short- and long-term health goals and planning while living in low-income. The themes of resiliency to resist oppression and racism and the persistence for increased quality of life will be further discussed and unpacked utilizing CRT framing after addressing the conceptual framework or the research questions. First, how the men understand and perceive their health and chronic disease will be addressed.

Understanding and Perceptions of health conditions and complex chronic diseases

All participants were aware of their health conditions from prior diagnoses they received within the health care system by self-identifying at least three or more health conditions they have had for six months or longer. Most of the men have heard of the concept of chronic disease but only 39% understood the meaning by providing a definition and could identify that they had chronic diseases. Each participant perceived their health conditions based on how much it was impacting their daily lives, or whether they were having symptoms that limited them from daily, to weekly or monthly on their activities and quality of life.

Elmar, 67-year-old, widowed, single, gay, Jewish Black man, with no children and who has high blood pressure, obesity, type 2 diabetes, heart disease, angina, and arthritis, shared this about his chronic diseases and his perceptions about his health:

> “Chronic disease means it is very serious and that nothin that you can play around with, and I don’t play around with mine. I do everything I can do that is natural and healthy. I don’t smoke, I don’t drink a whole lot, but I, know what I need to do and what my body will let me do. My heart problem started after the George Floyd died because I did not know how to react to things or how I would feel. But for the most part I have to try because I have no choice but to try. I have all these things I have to deal with and all the things I try to do.”

Jerome, 70, who is divorced and single, has three living children (son died a few years ago in an accident) who is a Veteran from Vietnam who has HTN, emphysema, benign prostate hypertrophy (BPH), hyperlipidemia, PTSD and lives with is 17-year-old daughter. He is a smoker but has been trying to cut back due to his significant dyspnea, his highest level of education is the 11th grade and explained this about how he understands his health:

> “My health has its ups and downs. I try not to get stressed about it. The thing that causes me the most concern is not going to kill me, I don’t think, is my COPD, my breathing, with my lungs. I have lived with it for so long that I just deal with it on a day-to-day basis. It works out. As long as I wake up in the morning, I am sure that I can deal with it again. I know my COPD is a problem, but I don’t know how I can say I understand it. I only know how I came to have it cause of what is happening.”

Marcus, 45, who is single and has type 2 diabetes (DM2), high blood pressure (HTN), and obesity. He completed his GED. He reported using the bus or walking to his medical appointments and has been diagnosed with HTN and DM2 since he was in his early thirties. He reported that he checks his blood pressure daily at home with an automatic blood pressure cuff.

> “I understand my health. I have to stay away from certain things and certain foods and keep taking my medications. Chronic disease means reoccurring and I check my blood pressure daily and my blood sugar. I know when it is high or low. I can feel the difference and feel more tired then I go and take a nap but I basically know to stay away from certain sugar, no sugar, I can have no sweets. My blood pressure has been running like around 120/80. I see my health changing for the better in the future because I got doctors working with me. Like I got everything that’s going to get me, that the doctor gives me to take for it and it’s working good for me. I see the doctor every 6 months and I go in if he need me to do a test or I have a question or something wrong.”

Darryl, 61, is single, never married, and has no children. He stopped taking medications eight months ago to treat bipolar, depression, chronic back pain, schizophrenia, hyperlipidemia, and HTN. He doesn’t like taking medications and describes his health as:

> “My housing does impact my health, trying to keep up with rent, borrowing money but I just deal with it. I have heard of chronic disease and it’s like something that you got and can’t get rid of it. I am not sure if I have chronic disease, I don’t know. I’m taking it one day at a time. No doctor or anyone has talked to me about my diseases being long term. I quit taking my medications 8 months ago. I am trying to wean my way off of them and so far so good. I didn’t even know I had high blood pressure until I got diagnosed with it so it really didn’t matter if I took it or not, that’s the way I look at it. I get depressed here and there but I just call my mom and other people. I don’t like taking pills, haven’t since I was a kid. I think my health will be normal as aging goes, things break down and that’s the way I look at it.”

Based on the participants’ past experiences, their symptoms, relationships with their doctor and other formal or informal supports, impacted how they understood and perceived their health conditions and how they managed their symptoms and health. The second research question addressed how the men managed their symptoms for quality of life.

Symptom management for qualify of life

Quality of life (QoL) was asked first before addressing how the participants manage their symptoms. Participants were asked to rate their quality of life on a scale from one to ten with ten being the highest or best QoL. The average QoL the men reported was 6.5 with the lowest rating of 3 (participant with frequent reports of chest pain, mental health and financial issues and lack of formal and informal support) to the highest of 10 (participant who had to manage his emphysema frequently throughout the day but had strong spiritual beliefs, supportive health care team and family). After discussing how each participant managed their symptoms, I asked them to define what QoL means to them, then if their QoL would increase if their symptoms were managed.

When asked about symptom management, men would initially share how they managed their disease. They often would describe how they took their medications, tried to eat low fat or no sweets, avoided salt, exercised or tried to quit smoking. Some of the men were able to identify some of the actions just listed as methods to avoid symptoms they had experienced in the past. The following are examples from what the men shared regarding quality of life and symptom management.

Lewis, 62, single with one daughter, with tenth grade being the highest grade completed, has the following dx: HTN, hyperlipidemia, DM2, chronic lower back pain from injury, mass in lung (continuing to watch), depression and stress (used to drink a 5th of hard liquor a day and now just has four shots of alcohol a day. The following is how he perceives his QoL:

I rate my quality of life at an eight. I sometimes like to eat sweets and if my blood sugar gets to 240 or 250 and I feel tired and sleepy. I take a 2nd metformin, and this happens about one time a month, but I don’t like to do that since it makes me nauseous but I drink a lot of alcohol so it probably doesn't agree with it. They did not tell me to take the 2nd one, I just do it if my blood sugar gets too high. I got a blood pressure cuff 3 months ago, I asked my social worker to help me get one. I only check my blood pressure when I have a headache but that doesn’t happen much. It is okay when I go to the doctor now and all my tests are good too. She changed 1 prescription for my blood pressure from lisinopril to losartan I think cuz my blood pressure was too high a while ago. When I use salt when I eat 3 meals a day, and sometimes I experience headaches, but I figured it just the salt. I have stress but try not to think about it and after I take some shots of alcohol, my stress goes away. I view quality of life as I would rather be here than in Chicago. They have wars with gangs with going back and forth and they is going crazy. It’s like gang warfare right now. My quality of life would be great if I didn’t have any symptoms!”

Joseph, 59, single with no children, completed up to 11th grade, reported a diagnosis of hypertension, lupus, arthritis, CKD, hyperlipidemia, obesity, has an in- home manual blood pressure cuff, sets up pills in pill box which he reported is easier than taking out of bottles because he was forgetting to take them. This is what he shared regarding his QoL and symptom management of his health:

“I rate my QoL at six and I think the meaning of QoL for me is enjoying life, look at the positive things rather than looking at the negative things, stay focused on good things, enjoy your life, do a lot of things you always wanted to do. I really can’t let this get me down on some of the things I did or should have and try to enjoy every day of my life. There are people with conditions worse than me with some young people in the hospital now and I am not in the hospital and on a daily basis, enjoy life. If my symptoms were managed, I think my QoL would be good. I manage my symptoms to stay alert on my condition, make sure I am doing what I should be doing, taking my medication on a daily basis, eating the right kind of foods, be active and move around. I check my blood pressure and have once a month and have no problem with it now, I bought myself a blood pressure cuff after my doctor said it would be a good idea to monitor my blood pressure. I saw someone set their pills in a pill box and I decided to try it and it helps a lot. I don’t forget to take them as much and much easier to open. I have seen my doctor about 6 times since COVID. Since Food Share went up with the pandemic it is much easier to eat healthy and buy more fruits and vegetables. With my lupus, I have more pain in my back, my side and causing me to be weaker and tired, which my doctor told me about. My doctor told me to watch my blood pressure and make sure I check my blood pressure and if I feel worser, I need to get to the ER and let them know. I am borderline with dialysis, and I see the kidney doctor 1 time a year to make sure it does not get worser to catch it in time. I have kidney issues from lupus.”

Floyd, 52, with some education in college for culinary arts, smokes 1.5 packs of cigarettes a day, has a history of incarceration and is going through a lot of stress now. He also shared that he had a five-year history of homelessness, experiencing food insecurity, and reported the following diagnoses: depression & anxiety, COPD, hyperlipidemia, insomnia, gout. He shared the following regarding his QoL and symptoms to manage.

> “I rate my QoL at 5. My quality of life has been getting worse over the last few years but just try to take it day by day. I really can’t speak to quality of life, I’m confused right now, I am not saying I don’t want to live but am just here right now. I’m just dealing with every day. I feel my quality of life would be higher if I had my mental and physical symptoms managed. I try to manage my bronchitis and do use an inhaler. I take my medications, but I have a sleep aide that gives me a lot of side effects and I need to be alert right now since I have a lot of personal situations going on. I will sometimes take it so I can get some rest. I have been quarantining myself, so I haven’t been able to get out as much as I used to. I have high anxiety levels and then I hear about the conspiracy and all that stuff, I don’t even want to leave and go out there. I know this thing has been really hard on the mental health patient, because I am one of them. I was diagnosed when I was in the correctional system, and I didn’t get medication and then was released.

Lorenzo, 50, single, has a daughter, and highest-level education of 9th grade. He shared that he has a history of substance misuse, had COVID, was getting the second vaccine, bipolar (recently hospitalized for mental health past seven months for 1 week), angina (chest pain), a stent placed 20 yrs. ago, chronic back pain, chronic constipation, coronary artery disease (CAD), and traumatic brain injury (TBI) from a violent attack in Chicago (where he is from). He also explained he has a recent five-year history of homelessness and received housing about 7 months ago. He discussed his quality of life and how he manages his symptoms:

> “My QoL is a 3.” Quality of life means your health, gotta have money. You can’t go nowhere or buy anything without money, to eat right, get soap, you gotta have money. If you don’t got money, you can’t by no soap or bleach to wash your clothes, stuff like that. My quality of life is poor living with my health conditions. If I didn’t have all this stuff with my body and my body is messed up right now, yes, it (referring to quality of life) would be better. I have to carry nitro all the time because the chest pain can bring me down to my knees. I take it 6-10 times a month or more and I always have to take 2 nitros for the pain to go away. I’ve had heart disease since the 1990’s and I had a clogged artery in my heart until one day I went to the doctor

> and then he ordered me to have a stent and unclogged the artery in my heart but I still have chest pains. I take baby aspirin too so I don't get a blood clot since it is like a blood thinner and keeps your blood thin. I take Tylenol for pain from my back issues a few times a week and legs. I was paralyzed for 7-8 days. I take my Seroquel for my bipolar, but I was hospitalized for about a week 7-8 months ago. I don't have the right medication for my constipation and my stomach is messed up. MA (referring to Medicaid) doesn't cover it. So, then I have to pay $16-20 dollars for the stuff that works. I am not worried right now as long as I pay my rent. I deal with my depression but what I am worried about is paying my light bill. I take BC an over-the-counter pain medicine and I buy the powder form and mix it with water for my head and back pain and it really works but it tastes nasty. Since I am not homeless and not stressing myself out right now, my bipolar is alright and I take my Seroquel 2 times a day and I am trying to get a psychiatrist, which is in my best interest. I feel like my doctor is not always giving me the right choices, I understand he is the doctor, but it is my body and I don't like it when the doctor tries to tell me that you need all this stuff. All I need is based on my symptoms and that is what the doctor should be doing to meet my needs. My doctor needs to believe that when I tell him about a certain problem, don't try and tell me it isn't a problem. Don't blow me off."

The men shared how they work to balance their daily lives based on what types of symptoms they experience to other circumstances, most of which are causing increased levels of stress. The men reported higher rates of QoL if they had less stressors and managed mental health or had their spiritual needs met. The third question of the study focused on short- and long-term health goals and planning.

Short and long-term health planning and goals

When asked about short- and long-term health goals and planning, most men shared their short-term goals at it related to their immediate situation but mostly focused on their health and long-term goals initially focused on goals other than health. At times for some men, the researcher had to explain what short term meant (two to four months). Short-term health goals and planning will be shared first from the participants and then long-term goals.

Short-term health planning and goals

Demetri, 44, has a girlfriend and has never married with no children. He reported he was recently evicted due to drug possession and selling, has his GED, with the following diagnoses:

multiple sclerosis (MS), chronic pain from it to legs, abdomen and back, and depression. He stated he sometimes uses a walker, cane or wheelchair for mobility based on his multiple sclerosis symptoms. He shared that he is currently staying with friends. He also stated he only has a neurologist and no primary care provider and was diagnosed with MS in 20's. He reported that he takes Davian injections every other day to manage his MS and girlfriend helps to give him his injections so he can rotate sites to inject. He currently reports taking over the counter (OTC) meds for pain (Tylenol) and amitriptyline for his depression. He rates his stress very high being homeless (8-10) and when his stress is higher, his MS symptoms are much worse. Saw his his provider once a month before COVID but now since COVID, hasn't been able to talk to them as much (using a friend's phone for the interview). The following is what he shared about his short-term planning:

> "I hope I can get back into my apartment again so my health can get back to stable, just a little. My girlfriend wants me to go to church with her sometime and I have no problem with that and would not mind. I will say my short-term goal is to make sure I keep taking my medicine. I would like to have a case worker to help me more with housing and other issues. I would love that. Anywhere I can get more support and encouragement would be good."

Lenard, 55, married with no children. His highest attained education was eighth grade. He is from the South and moved here for better health care and for a better life. He reports having the following diagnoses: asthma, hypertension, DM2 (insulin dependent), sleep apnea, chronic pain, hyperlipidemia, lower extremity edema, CAD, GERD, benign prostate hypertrophy, schizophrenia, bipolar, a heart attack in 2012-had three stents placed, chronic kidney disease (CKD) stage 3. He reported that he takes over 20 different pills, but doesn't know what they are, and they are packaged and delivered by a pharmacy. He has a community nurse from a community treatment alternative to assist with medications and administers a weekly injection for his schizophrenia. He gives himself insulin 1 x week and before COVID was seeing doctors every 3-4 months but since COVID has only talked to them on the phone twice. Lastly, he feels unsafe where he has lived over the past 10 years due to drug dealing and only goes out of his apartment during the day. He is very connected with mental health support in the community and received COVID vaccine and shared the following regarding his short-term planning:

> "My health has changed a lot because things happen. I just need to look at what I am doing and to take care of more information that I can get down and can keep it stable. My kidneys are at a 3 (referring to stage 3 renal failure) and I hope to bring it up or continue to stay the way it is for a while. I talked to one of my case workers and told them I need more help in the home because every time I bend over, I get lightheaded and I can't reach my feet or legs for care due to my back pain. I am upset that I cannot reach my shoes to tie them, so I bought slip on shoes, so I don't have to bend over.

The participants' examples regarding short-term health planning demonstrated how the men viewed their short-term goals as they related to their circumstances either with housing insecurity or increased symptoms where they needed more interventions to manage their health and participate in daily activities. The last section of inquiry focuses on long-term health planning that the men shared.

Long-term health planning and goals

Initially the men shared long-term goals of moving closer to family, seeing grandchildren more with several men hoping to get better, heal and not have to take medications anymore. Some hoped to live another five to ten years, whereas a few hoped to live a very long time. When asked how they would like to be cared for when they need more help, many stated they wanted to remain as independent as long as possible. For most of the participants, the question was posed again but related it more to aging and most participants were more open to discussing how they would want to be cared for. Besides remaining independent, most men want to be cared for by their families. If the men's families are not able to care for them, a few of the participants shared they would be open to a nursing home or as some referred to it as “old folks home”, hospice or in home nursing care. The majority had not heard of advanced care planning (except for the two men who were Veterans) and power of attorney for health care (POAHC). Thirty-five percent of the men already had a POAHC in place where they had family as their decision maker if they became incapacitated and 23% wanted more information and planned to talk to their families and doctors about it. The following will address how the participants viewed their long-term health planning and goals.

Marcel, 54, was recently released from prison where he attained his GED. He stated he has the following diagnoses: hypertension depression/anxiety, arthritis (knees), chronic sinus infections, COPD-asthma, and hyperlipidemia. He stated he got COVID in prison which was hard on his lungs with his asthma and smoking. He also shared that his mother, who he adored, died while he was in prison. He reported he has three kids and two stepchildren. He stated he has strong religious beliefs and prays every morning. He shared that he wishes to be resuscitated if needed but does not want to be on machines to prolong his life. His daughter who is a nurse is his POAHC. The following are Marcel’s long-term health planning and goals:

> “I want a doctor who will listen to my needs and not try to tell me they know what is wrong with me. I want to get my own place and start a business before I die. I want to be able to take my grandkids to Disneyland. I have lived for 54 years already, and most black men don’t make it to my age, all the guys I grew up with are dead and gone from gun shots, drug overdose, gang violence. I hope to be a poster child for some of the people I have met since I got out. I am going to reach out to these cats I have met since I have been out of prison and show them how to change their life like I did and tell them that they will run into obstacles but if you use the support team that I used, you can’t go wrong. As I am aging, seeing the doctors, following their instructions, and hope for the better. A lot of damage has been done to my body and so it needs to rebuild itself as I get older. My daughter, who is a nurse, said I don’t have to worry about going into a nursing home and that she would take care of me. When I cannot take care of myself, I will already be in Texas, where she is, and she will be taking care of me. The role of my doctor as I get older is to be honest, professional, and caring, don’t lie and don’t beat around the bush and just tell like it is, you know, don't give me false hope. If I have six months to live just tell me and be like you would want to be treated. I want an honest, open relationship and tell

> me how it is. I have a POAHC, and it is my daughter, we are all set. I want CPR should I need it but if I am on a machine, I am already dead, a donor, so whatever they can extract to help somebody else, do it."

Deion, 47, has been homeless for the past two years and stayed at the men's shelter until the gunshot attack last month and now won't go. He also shared he was in the emergency room (ER) within the past year for a heroin overdose. He shared he has the following diagnoses: glaucoma, GERD, hypertension. inguinal hernia, substance misuse, bone spurs on right arm and elbow (from a previous injury and is unable to straighten his arm), disc disease to his lower back with 5 bulging discs), rates his pain at an "eight" most of the time, and has liver disease. He also shared that he has a fiancé and a history of incarceration. He was taking Vicodin for management and when they stopped prescribing it, he switched to heroin. He also reported that his brother died in 2015 from a heroin overdose in Chicago. He currently stated he has been drinking a lot of alcohol and has decreased to eating only 2 meals a day due to diarrhea the past six months and nausea, which he is very concerned about. He is not taking medication for his glaucoma but knows he needs to be on it and has one year of college attained while incarcerate. He reports being a smoker and has support from his mother, brother, sisters, and son. He reports that he had COVID and is in the process of getting 2nd vaccine. He is a full code but wanted information about POAHC. He is currently not taking any medications at this time, has not had a colonoscopy, and recently visited the ER visit due to pain from his left side to his chest but and a myocardial infarction was ruled out. Deion shared the following about his long-term health planning:

> "I see my health changing for the better and I'm starting to realize you I am not getting any younger and I used to hate veggies, now I eat them, but I don't feel as healthy as I used to so that is kind of scaring me, you know. But I see myself straightening up and getting better. I plan to go see my doctor, get the tests run, figure out what is going on and let me know everything that is going on and what I need to do and what he asks me to do, I'm gonna do, you know, like I

said, I mean, I know I have a lot of symptoms so I can start living right by doing what I need to do to get in good health. I also won’t mind being in an old folk’s home when the time comes because I would rather be around a lot of people than being alone. I want the doctor to give it to me straight when I am getting worse, and I want him to make sure I get it. Don’t make it sound like something when it’s something. I see a lot of that with doctors, you know. I have seen doctors really not tell you. I would love to have a real close relationship with my doctor because I have never had that. I have heard of POAHC but don’t’ have one and I want CPR done if I need it. I would like more information on POAHC too.”

Jim, 58, is single, and his highest level of education was the ninth grade. He has a daughter who lives nearby and moved to the area from the South with his mother when young. He reported the following diagnoses: chronic pain from degenerative disc disease, hyperlipidemia, eczema, and DM2. He shared that he has lost 70 pounds over two years because his doctor told him he was a “walking time bomb” and needed to make changes. Due to this weight loss, he stated he has been off his medications for DM2 and hypertension. Had a colonoscopy three years ago and the results were negative. He has a history of homelessness but has been in his apartment for the past one and half years. He is a full code and wants more information about POAHC and plans to talk to his daughter about it. Here is what is disclosed about his long-term health planning and goals.

“I want to have a close relationship with my doctor where they spend time with you, listen and talk with you. I have to take care of myself on a daily basis and until the end. My wishes are that my I hope my health doesn’t get bad or get worse. I don’t think about what might happen to my health but if something comes up from a checkup, I would deal with it. As it comes. I don’t need to worry about something that may never come. As I get older, I would like to be around my family, kids, grandkids and keep my family close. I don’t want to go to an old folk’s home, I want my kids to take care of me. I want them (referring to the doctors) to tell me everything about my health, so I know what needs to be improved on, let me know what to do. I don’t want them to think the way they think, I want to know everything that is going on with me, so I know it. I have not heard of POAHC, but I know I want CPR if I need it. If I am on machines and there is a possibility of me recovering, I want to be on machines. I know there have been people that have been on them for years and they have come back. I have not talked to my daughter about this, but I will plan to so there are no surprises for her.

Tom, 55, reported his highest level of education was the 9th grade. He shared he has a son in prison and two daughters and is divorced. He reported that he drinks two to three beers a day and lost his license to drive after receiving a driving under the influence (DUI) ticket in an accident one year ago. He stated he has the following diagnoses: hypertension, asthma, substance disorder, insomnia, chronic pain to left ankle from an earlier accident and stated it is always swollen. He said he has a "pin" in his ankle and a lot of pain. He shared he has been homeless for the past twelve years and takes two medications for HTN, 2 inhalers and another pill for his heart but doesn't know the name of it. He shared his frustration with his with having a hard time getting medications since his pharmacy won't deliver them due to his homelessness and tries to pick them up but with COVID it's been hard. He shared that he was not planning to get the COVID vaccine as is afraid of it. He stated he is a smoker and reports high stress with not getting his stimulus check and issues with getting medications and being homeless but states he is always trying to deal with it. The following is what Tom shared about his long-term health planning and goals:

> "I gotta cut back on smoking cuz I got no money, but my doctor wants me to stop smoking because of my asthma. I just want to take my medicine and stay alive. I want to go to Chicago and let my sister take care of me when I get bad. She is one year older than me. She is good health and she always tell me to come up here. I have not heard of a POAHC, but my daughter is on my life insurance. I do want to be resuscitated but if I have to be on machines to live, I want to be taken off of them. If I don't survive, then that's your plan in life, yes, they need to take me off. I would like information about POAHC so I can talk to my daughter about it."

The long-term health goals and planning of the participants focused on getting better, healing or maintaining health to live longer and spend time with family. When asked further about how they would like to be cared for as they age and as their health worsens, many of the men shared that they want to be cared for by family. Daughters, sisters or partners of the participants were identified as the preferred care giver by the men when they decline and need that support. Currently, these same females are strong informal supports which the men shared as important roles in their lives.

When asked about the role their doctors or PCP should have as their health declines, all the participants shared, they wanted supportive, kind, honest and understandable communication with choices regarding their health and prognosis. Although most men requested that they wanted to be a full code or to be resuscitated if their heart and lungs were to stop, several men shared that if there was no hope or if they had to remain on a supportive, life-sustaining machines, they desired to have them removed from them. Lastly, the two themes, resiliency by resisting oppression and racism and persistence for increased quality of life, will be discussed which were identified utilizing CRT analysis from the men's responses to the above research questions.

Themes

Resiliency to resist oppression and racism

The resiliency of the participants was a common theme throughout the entire study as the men shared their experiences while living with complex chronic health conditions. Resiliency is defined as the capacity to recover or withstand difficulties or toughness (Oxford Dictionary, 2023). A notable phrase that many men used when describing how they manage or cope with specific situations such as managing their symptoms, stressors with finances, the pandemic, or implicit or explicit racism was "deal with it". The phrase "deal with it" is a term that dates to the 15th century meaning to manage or handle someone or something that is typically unpleasant. Resistance was chosen with resiliency as it is an action that has strong roots and foundation in CRT, from the grandfather of the theory, Derick Bell.

Resistance is defined as the act of pushing back against an obstacle or challenge while resilience is the ability to adapt and recover or bounce back from adversity (Robinson, 2023). Although the men in this study have demonstrated resiliency their entire life, they have had to resist the barriers and/or intersections of marginalization they live with, by identifying as Black, low-income, and living with disabilities (chronic health conditions). The U.S. society further oppress persons the more they identify with multiple marginalized entities. The men of this study have shown strong resilience to arrive at the current positions they exist in, but it has not been without resisting racism, classism, and ablism in all its forms in the process.

Antiracist activism has Black radical tradition that CRT draws upon. Derrick Bell, a legal scholar, was on the frontlines of fighting racist legal doctrine then drew from that experience to create the field. Radical realism is congruent with the processes of resistance according to Derrick Bell (1995), “the fight has meaning . . . the struggle for freedom is at bottom a manifestation of our humanity which survives and grows stronger through resistance to oppression, even if that oppression is never overcome” (p. 308). Therefore, CRT scholarship depicts from the stories that center on the life experiences from the voices of populations of color to not only challenge racism but validate its reality (Christian et al., 2019).

The men from this study have demonstrated resiliency by resisting oppression and racism by relocating from unsafe cities where unemployment, limited opportunities and high crime were prevalent. None of the participants were from the area where the study was conducted and most of them moved to the study’s location during the Next Great Migration that started in the 1990’s as industry within cities in the Midwest began to move out, leaving many jobless. Another example of resiliency by resisting are the men who have or want to overcome their distrust (historically has been built on oppression and racism) of the health care systems to seek medical care especially as their bodies change with middle age. They have lived within the intersection of being Black, a male, and living in low-income their entire lives and have had to resist what society has unjustly handed them from intergenerational and racial trauma involving early exposure to violence and death; physical injury from either excess violence or high labor jobs; unemployment; lack of educational opportunities; financial hardships; and premature onsets of complex health conditions. The following are examples of how the men have resiliency by resisting oppression and racism throughout their lives.

Quarren, 48, is an occasional smoker with four children. He is single and has a sister and mom who support him now. He shared his history of incarceration and lost his disability checks while in prison but has applied and has been delayed with COVID. He reported the following diagnoses: hypertension, hyperlipidemia, PTSD, GERD, arthritis to back and knee, and uses a cane sometimes. He takes Tylenol 2-3,000 mg a day for pain and feels discriminated against by doctor with pain management due to his race. He also shared that the doctor was also refusing to see him since has missed too many appointments, but Quarren stated he has a lot of transportation issues to get to appointments, does not like to take medications but will take meds for acid reflux, also reports they found a tumor on his pancreas that they are watching and now it is not cancer. Has had steroid injections for pain but has not helped much and wears off in a few months. Received first COVID vaccine and is getting the second one in a week or two. He knew what chronic disease was and knows he has chronic pain in his back and knee. He defined it as something severe, like a bad disease, and he reports that he smokes marijuana to help with stress, has two years of college while in prison. He wishes full code and knows what a POAHC is but doesn't want to address that now. He moved here due to the violence he experienced while living in Chicago:

> “I moved here when I was 19 years old from Chicago. There was too much of a nigger chillin vibe with killin, gang bangin. Way too much stress and drama. I have PTSD from it. It was not a good, centered life for me, so I moved here with my mom.”

Floyd, another participant from above, shared this about Black men’s fears, masculinity, and resistance due to structural racism and oppression from the legal system.

> “Thing was we would just focus on more mental as for a as physical because you know my main was just trying to get the pain to go away as opposed to being treated, you know because there are a lot of black men think like that things like that you know, in our culture and a lot of us try not to go to the doctors, we just try to deal with the burden. I think it is more of an embarrassment or like it’s a weakness. People going in and getting on medication and it seems there is an agenda, as opposed to just being healthy. There are a lot of people that don’t go to the hospital with gunshots or cut at home from an accident because of personal reasons but a lot is because of the judicial system. They may have warrants on them and there is a lot of that going on. There are a lot of unhealthy of us walking around right now. Maybe it could have been prevented or maybe not. I just blamed it on alcohol or something like that as I got older and there was more to it than that. When I try to stay young in my mind, it doesn’t always coincide with my body. Once you get older you probably need to go check it out and my dad always went to the doctor and he died when he was 85 yrs. old and he had all kinds of complications after that he used to eat a lot of pork, had high blood pressure and diabetes. A lot of black men don’t like to be on medications or multiple medications. From a person point, when in prison, a lot of Black men are strung out on meds walking around like zombies. I am not going to be strung out on stuff when they don’t know what is good for me. It is a man thing or seen as a weakness to take medications or depending on somebody else to tell you how to do what you need but that is not just for Black men. They want to fix it themselves without any help. There are Black men I know and their bodies might not be reacting the way they want them to and the pain and the mental health all starts kicking in and I tell them, hey man you need to go get some help.”

Willy, 59, reported that he smokes one pack of cigarettes a day, completed his GED and has a supportive girlfriend who he has been with for one and half years. He shared he does not have a PCP and has been afraid to be seen by a doctor due to money and what they might say about his health, but he knows he needs to go in. He stated he has the following diagnoses: blind in left eye due to cataracts, depression, gastro esophageal reflux disease (GERD), and sciatica with chronic numbness to lower extremities. He shared the following about his resiliency and contemplating his fears and distrust with the health care system.

> “I don’t think a lot of Black men like to go to the doctor because they think they are going to owe a lot of money and they are scared of they will say. They think they are superman nothing ever happens to Black men, like we are strong like gorillas or whatever, you know. They think they are invincible, and they are not. They want to live their life and I say if you don’t go (referring to seeing the doctor), they aren’t going to live longer if you don’t go, but knowing is half the battle or more. A lot of Black men don’t want to know, and I say, why don’t you want to know? I need to get out of that thinking too, they don’t want to know and we come up with a lot of excuses except for the right one that is for sure.”

Larry, 58, is a smoker who reported his highest level of education was the 10th grade. He has seven children and nine grandchildren who he is very proud of. He has a strong spiritual life and prays daily. He shared that he has the following diagnoses: arthritis to his knees, degenerative disc disease, GERD, sleep disorder, depression, pre-diabetes, hypertension, and hyperlipidemia. He said he also has a history of incarceration, was on oxycodone for pain up until 2013 and now not on anything but has a pain management appointment coming up soon which his primary MD helped him get. He stated he has a good relationship with PCP and trusts him. He stated that he has been seeing his PCP every two weeks since he was hospitalized for a ruptured ulcer in his stomach six months ago which was an intensive hospitalization with drains and four antibiotics. Lastly, he stated he moved from Chicago in 1984 due to too much killing, has been in transitional housing for 1.5 years. The following is how Larry has resisted oppression and racism:

> “My stress and depression can get rough for me if I can’t get the place I wanted or when racist scum person don’t treat me well or say something to put me off. But other than that I have been managing my stress. I try to stay out of their way and avoid negative things.”

The second theme that was identified from the narratives of the participants is persistence to increase quality of life. After most of the men relocated to the area of the study, their resiliency from not only resistance was noted but from their ongoing persistence to have quality of life physically, mentally, spiritually, and emotionally. The second theme will now be discussed.

Persistence for increase quality of life

The participants, even with the many limitations, barriers and struggles they had endured, continued to persist for quality of life as the average QoL reported was above average at “6”. The definition of persistence is the action to continue firmly or steadfastly in some course of action, purpose, or state, especially despite opposition (Dictionary.com, 2023). The men demonstrated their ongoing persistence while living with their complex health conditions to manage their symptoms by either of the following: 1) the desire to seek health care due to changes in their conditions that were concerning to them; 2) continuing to follow up with the doctors or PCP during the pandemic either through phone calls or clinic visits with the average frequency of PCP follow up for all the men, before the pandemic, was every six months; 3) desire to maintain their formal and informal supports of family, friends, or pastors; 4) striving to adjust after being released from prison to improve their lives or if they are homeless, goals to find housing; 5) most of the men believing they can improve their health and quality of life by managing their symptoms and diseases through adherence with the prescribed or their personal choices health regime; 6) several men having either their POAHC in place or a desire to consider one; and 7) reflecting ahead to their future needs and wishes as they age. The following demonstrates how the participants persist for quality of life.

Bernard, 58, is a smoker (one pk a day) with the highest education of 11th grade single and has 2 children in the area who support him. He reports the following diagnoses: substance disorder (alcohol); bipolar, dissociative disorder, hypertension, hyperlipidemia, DM2, asthma, neuropathy, seasonal allergies, deterioration of the spine, and is prescribed and takes medications for his diseases. He reports that he does not have air conditioning and only a fan and doesn't feel they (apartment management) are fair with air conditioners. He has a fear of losing his mind and has a crippling spine. He says he has had increased fears and isolation with COVID for past 1-2 years and more stress and feels his mental health has gotten worse with COVID. Bernard shared the following about his persistence for increased QoL.

> "My QoL has gone down with COVID. I had moments with my psyche. QoL means to trying to changes some of the things or the majority for things for what one wants in life, you needs, the basic every day to cope with life you know. My QoL has been changing before COVID, in fact I was trying to blame it on that. Hopefully, once I get the 2nd shot (referring to COVID vaccine), I can get out more and doing the things I was doing before the virus with walking and exercising. My long-term wish is to be healthier as I get older and be able to function on my own. Those are my main concerns as well physically and hope that I can beat this DM2 high blood pressure. I hope this deterioration of the spine doesn't end up crippling me, or losing my mind totally. I don't want to be cared for. I want to be able to care for myself. If I can't care for myself, hopefully my children will be there for me. My doctor has talked to me somewhat about my diseases and the future but I want the doctor to be a good listener and try to help me out as I go and don't keep anything from me. I wants to know. The earlier the better, if you are going downhill you can stop that roller coaster ride downhill and pumps some breaks and level off. You know, you don't want to hear the truth or hear bad news but yes, I wants to know. I'm not afraid of dying, I am not afraid of death. I am very spiritual but not just for my sake but for my family's sake, I would want to know the truth. I have heard of power of attorney but not advanced directives. I think I have that done and my it's my daughter. I want to talk to my doctor about that more to make sure because it is so important."

LaVonn, 60, is single and recently released from prison (2 months) after being in prison for 24 yrs. He has a history the following diagnoses: bipolar, schizophrenia, DM2, paranoia, arthritis to back, hypertension (on 3 meds for that) substance disorder (both illicit and alcohol consumption) has not been on meds for his mental illness since he was incarcerated and currently trying to find mental health support. He reported finishing his GED in prison. He shared that he has a daughter, brother and sister to support him, and he takes medications for his diseases but keeps forgetting to take them so he got a pill box and set up an alarm on his phone to remind him to take them. While incarcerated, saw the doctors every six months, and received his COVID vaccinations while in prison. LaVonn shares how he persists in increasing his QoL.

> "I know about diabetes from a pamphlet I read about DM2 because my mother passed away from it. So, I know it is serious and I have many chronic diseases. I think I am maintaining my health since I watch what I eat, exercise, and I need to keep my body moving every day, take my medications but I need to see a doctor to get my levels tested (referring to blood sugar, blood pressure). I need my A1C to stay below a 7. Reading the pamphlets, talking to the doctors about my different diseases like blood pressure, cholesterol, so I read that and study that and try to stay under the levels. Quality of life means keeping my health together, my mental and physical health intact, family, friends, my family close, my kids and my surroundings. That is quality of life which will keep me motivated to stay focused on living as long as I can spiritually and is another thing that will help you, you know that's pretty much low quality of life for a person to just survive. If I had all my symptoms managed I think I'd be you know, myself would probably be better. I think I could add another 5-10 years to my life, something like that and my QoL would go up to a 10 if my symptoms were all managed."

Shontae, 44, is single with a long history of incarceration since he was eleven years old. He still must wear a GPS bracelet and feels the legal system where he lives is very racist and not fair. He is homeless and reports the following diagnoses: hypertension (reports headaches three to four times a day), depression, hyperlipidemia, substance disorder (alcoholism), insomnia, chronic pain and arthritis (work and has remains of a bullet still in him that they could not remove since it is around a major artery) and bipolar. He stated he doesn't like taking pills and is currently not taking any for his conditions but was taking them regularly when in prison. He has GED and four certificates he attained while in trade school during his incarceration. He shared he has four children, has his POAHC in place and shared he is a full code. He reported he prefers to use folk remedies that his grandmother taught him how to use and primarily raised him. He shared that he recently reconnected with a church and has been praying a lot and has new connections with a support system. He also shared that he recently stopped drinking alcohol and is feeling better. One year ago, he stated he was hospitalized in Florida for mental health and alcohol use, similar to chapter 51, he said. He has received his first COVID shot and waiting to get the second vaccine. Shontae shared the following about his health and persistence for QoL.

> “I think my health will get back to normal as I am making preparations for change. My pain is from the whole bullet, and it was too close to a major artery so they didn’t want to mess with it. It’s been a decade or more since that happened, it was two different guns and two different guys shooting at me. The bullet moves around since I try to be active, and I have had labor jobs in the past and pinches the nerve every now and then and can be really strong bold pain. I am talking about excruciating pain, like so I go through it from time to time when the weather changes. I know for a fact that my health will improve but as I age and need more help, like everyone else, I wouldn’t want to go to, like, an old folks home or nothin. But if my kids were too busy that they couldn’t give me the proper care, then that would be the best place for me. I think when I get worse my doctors should be proactive and check on me and make sure all things is going in the right direction, I would think. I want them to be open and honest about everything and tell you things that you can do to improve your health. I want my doctor to be a good listener but they have selective hearing so they do what they do regardless. I don’t want the wrong medication, which is the one thing I am scared of and not kill myself by mistake.

Ray, 64, is single with seven children, and many grandchildren and has never been married. He reported that he drinks beer and smokes cigarettes on a daily basis. He stated he has a bachelor’s and master’s degree in business, used to work for the FBI. He shared he has his POAHC in place and is a full code. He has a strong Christian background and attends church when he can but has been limited with COVID restrictions. Has lived in his current apartment for 22 years and feels very stable. He drives himself to all his appointments shared and he has a very supportive health care team. He reported having diagnoses of hypertension, DM2, heart failure, BPH, PTSD, schizoid disorder, heart murmur arthritis to hips (had total hip surgery), lower back pain, stroke in 2020, obesity and cataracts. He reports setting up his medications each week in a pill box. He reports seeing his doctor in the past year eight times. Ray shared the following about his health as he continues to persist with his health and mortality.

> “My health has been going down over the past 22 yrs. I can’t walk far now because of the pain to hips, back. I have a therapist but no psychiatrist, but I have a lot of other doctors, urology, vascular doctor for my carotids, diabetes. I know how to get the best out of them and I do. I hope my health will change, resolve itself. I know it can get worse but I ain’t looking for, I ain’t

looking for the worst of the worse. I am looking for it to take off a little bit. I know I gotta leave one day but uh, I mean I watch the news, I see the people with the coronavirus, I don't wanna get like that where I'm on a respirator and all like that. I don't wanna die alone. I don't want that to happen. I know I gotta die one day, everybody know they gotta die one day but I'm living for the moment at the present time."

Limitations

The qualitative study of gaining increased understanding and perceptions of middle aged and older, low-income Black American men with three or more chronic conditions provided a space and time for each participate to share their stories of their lived experiences regarding their complex health conditions. Critical race theory was the guiding lens utilized throughout the entire analysis, and it became clear that another theory to assist with the analysis would have been the life course theory. The life course theory (LCT) has been seldom used to examine the lives of racial/ethnic minority groups and how systemic racism impacts social and health inequities across the life course (Chatters et al., 2021). Based on how much the participants were willing to share not only about their current lived experiences but also the effects of their past on their current situations, the LCT would have assisted with the analysis.

The goal of at least 30 participants was the recommended qualitative participation. The significant stories and experiences provided a thorough, in depth, rich narrative and provided the research team the experiences that many of the participants shared regarding the topic of the research study, further providing trustworthiness to the study. Since the study was conducted during the pandemic in the spring of 2021, all interviews had to be conducted via phone versus the original plan of in person, to protect the participants' health due to their high risk with comorbidities and age.

Qualitative research typically provides the most breadth in in-person interviews as phone interviews as barriers to other nonverbal observations. In retrospect for the researcher, the phone interviews were honest, intimate conversations that ended up lasting as long as ninety minutes for a few of the men. The method of communication via phone helped to ease the discomfort of talking to a stranger in person, the need to meet at a certain time or location was eliminated and the interviews were scheduled quickly after the initial contact with the potential participant. Therefore, phone interviews for this study decreased participant burden, which the literature has supported for the same rationale of conducting phone versus in-person interviews.

The high volume of participants and detailed stories of their experiences led to a large data set to disseminate and the need to complete the analysis manually instead of using a computer program to help manage the data set. More time was needed by the research team to analyze the data, and the lead researcher continued with reflection and practiced reflexivity daily, lasting almost two years to be true with integrity to the data where the time and stories that the she was privileged to witness. Perhaps other methods to manage the data would have eased burden on the research team.

Discussion

The research team attempted to answer the research aims through individual, phone interviews among low-income and middle aged and older Black American men living with complex chronic health conditions as it related to their understanding and perspectives of their complex chronic health conditions, symptom management for quality of life, short- and long-term health planning. The method of recruitment, how inclusion criteria was established, and the lived experiences of the participants was captured to further understand the stories and experiences utilizing thorough, diligent, and abundant time to increase the understanding of the men's journey with their health. In addition to presenting the findings, analysis of this data was threaded throughout where two themes were identified, resiliency by resisting oppression and racism and persistence for quality of life.

As the data was analyzed it became clear that based on what participants shared from their historical life to current context of lived experiences that the life course theory would have been beneficial with the dissemination of the detailed stories shared. In addition, the levels of inquiry were similar to the socioecological theory, which focuses on individuals, their communities, organizations, environment and policy. All these topics were addressed as men answered questions and shared their assets and barriers of their lived experiences in aging and their health.

Younger participants received formal medical support but typically had diseases that were complex and included a mental health diagnosis. Trust in the health care system by some of the men led to avoidance of seeking health care support, or not having good faith with their providers based on past discriminatory experiences. The geographical area or county where the study was conducted does have the lowest ratio of patients to doctors (770 patients to 1 PCP), including mental health providers (220 patients:1 providers) in the state of the study. Within this county there are also abundant social programs to support those in need of additional resources (County Health Rankings, 2023). Unless the men had insecure housing, financial hardships or just released from prison, most had Medicaid and or Medicare health insurance and some income from their disabilities. The greatest support and need of all the participants were men who were recently released from prison and those with housing instability in attaining health care and income.

Of the men who had stable housing and income, most were managing their diseases and symptoms either daily or several times a week. The actions of managing their diseases or symptoms were most men’s goals or short-term health goals, although only a few men could identify short-term health goals. All the men were able to identify their health conditions or diagnoses but did not always understand the complexity of each condition or how the conditions impacted their health. Only a few men knew about their diseases where several did not know how their diseases would progress.

Most men reported taking medications to help their conditions or symptoms and were implementing non-pharmacological methods, such as rest, deep breathing, meditating, elevating extremities, or using supportive braces to joint areas. Most men had an idea of the types of medications they were on to treat their diseases, but several men reported they don’t like being on medications, with long term goals of “getting better” so they could stop the medications. One participant stopped all medications eight months prior to the interview and another participant decreased his medications or some were on hold due to his intentional weight loss and increased activity. There were a few men who shared they were not receiving medications to help with their conditions and had increased distrust among their health care providers along with feeling discriminated against because they are Black.

Long-term health goals were more easily determined by most participants that included trips, moving, housing, income, spending time with family and friends. When asked early in the interview about quality of life, most men rated their quality of life at a six or higher. When asked later in the interview after symptom management was discussed, most men shared that their QoL was lower than or the same as what they reported first but if their symptoms were better managed, their QoL would increase from their original report, with some stating as high as ten.

When advanced care planning, as it relates to long-term health planning, was discussed only two men who were vested within the Veteran Administration Hospital, were familiar with the term and had them in place. Power of attorney for health care was discussed as what the men's wishes would be if they were not able to make the decisions for themselves. Most men knew or had heard of a power of attorney for health care. They shared what their desires would be based on their situations. A few of them had their POAHC already put in place with their health care providers.

When the of topic illness progression or end-of- life was discussed, many men first shared they wanted to be independent. After the interviewer rephrased the question, or stated, "But what if you are not able to care for yourself or be independent with daily life activities?", the men were willing to share what they ultimately wanted if they could not care for themselves anymore. Most men wanted family to care for them. There were a few who wanted nursing care in their home and two men shared he would consider hospice based on how their loved ones were managing the care of them and needed more help. A few stated they would go to a nursing home if their family could not care for them, and one participant stated he would like to go to a nursing home so he would not be alone. Those that did not have a POAHC requested more information about the POAHC where copies were made and given to them. Several men who either didn't know how their illness would progress, or still needed to talk to their family about their wishes and completing the POAHC, stated they planned to follow up.

Lastly, when asked what the men felt was the role of their health care provider as their health declines or worsens, most of the men shared honest, respectful, understandable, and caring communication. The Pew Research Center published findings from the research conducted addressing Black American's views on health disparities and experiences with health care (Funk, 2022). The study revealed that 47% of Black Americans revealed health outcomes for them have improved, where 31% shared it stayed the same and 20% felt it has gotten worse.

Black Americans shared their main reason for health care outcomes worsening is less access to quality health care along with environmental quality issues among Black communities and medical centers and hospitals giving lower priority to the well-being of Black Americans. When asked about their own health experiences, Black Americans reported the quality of their care to be positive; yet a majority of 56% disclosed having at least one of several negative experiences where they've had to speak up to be treated with more respect and get the proper care, they felt they needed. Most Black Americans did not express an overall preference to see a Black PCP for routine care where 64% shared it did not matter the race or ethnicity of the health care provider, although 31% shared they would prefer to see a Black PCP (Funk, 2020).

Conclusion

The lived experiences of the participants demonstrated that racism and classism have increased the participants' risks of living with chronic social determinants of health (SDoH). This study shed new light on how low-income Black men have been living with intergenerational and racial trauma and their resistance to survive to middle age and older. Several men shared the ongoing daily stress of related to the restrictions of COVID but men experiencing homelessness, financial hardships or who were newly released from prison experienced even more stress with day-to-day persistence for their quality of life with some using of alcohol, smoking, or using illicit drugs to cope.

With the many barriers, injustices and suffering the participants remain resilient and have persisted their entire life as they continue to move forward with family, friends, and health care support to improve health by identifying their daily interventions to improve their quality of life and ultimately discussing their long-term health plans and personal goals.

The qualitative study gave an opportunity for a population that is marginalized and rarely heard, the opportunity to share their experiences in life as a low-income, Black American men. The men willingly shared their stories to further inform me about their experiences living relocating to the Midwest earlier in life to the time of the interview. Their choices at a younger age to resist both racism, violence and trauma and succeed to middle age and older has increased their quality of life with future health and personal goals and how they want to be cared for with illness progression and end-of-life care.

Recommendations

Further action is needed to provide other opportunities and interventions with an upstream approach to address racial inequalities and inequities that continue to impact and traumatize Black men. Culturally safe mental and physical health care is needed for this population. Additional research addressing the disparity and gap in health care support and guidance for Black men during their re-entry transitions from prison with the support of community nurses in collaboration with multidisciplinary health teams can assist with building relationships and trust with this resilient but vulnerable aggregate. Addressing racial issues and trauma at earlier ages among Black males is imperative especially when homicide and unintentional injuries was the number one cause of death among Black males ages 15-44 years in 2017 (Heron, 2018).

Notably, the state of where the study was conducted had the second highest death rates among Black Americans, 1318.60 per 100,000) only behind Mississippi who was first with 1, 331.90 per 100,000 in 2020 (Kaiser Family Foundation, 2023). Pew Research Center reported in 2020 that overdose deaths among Black American men increased by 213%, which was the leading race/ethnicity and gender in the United States. Pacific Islander, Native American, and

Hispanic men's deaths by overdose increased in 2020 but at slower rates compared to Black men (Gramlich, 2022). This same state's Health and Human Services Department revealed significant racial disparities in COVID 19 cases among persons of color in 2020, with Native Americans having 1.2 times greater death rates, Black persons have 1.4 times rate of hospitalizations and Latinx 1.4 higher rates of COVID cases reported compared to their White counterparts (Gramlich, 2022).

Further research with this aggregate using a theoretical approach of CRT with the life course theory and socioecological theory is needed to further unpack and identify how U.S. society needs to address these injustices and suffering among all ages of Black American males. Providing culturally safe care to Black men in mental and physical health care settings as well s in all health care curriculums is necessary. Ideally, having Black providers to provide the direct care would be the goal as this has been the preference, but based on some of the participants of this study and the study from above, respectful, thorough, equal quality of care delivery and collaborative approach with PCP's and Black Americans was desired, although most health care providers identify as White.

The goal of teaching CRT as the overarching lens in health care curriculum along with cultural safety, life course theory and socioecological theory would assist future health care providers on the historical as well as the contextual injustices that have occurred and continue to occur among Black Americans. More importantly, self-reflection and reflexivity are required from first learning how best to care for those persons living within intersections of color and other marginalizing contexts and it should be a lifelong journey for the health care provider.

Lastly, more research is needed to further identify how community health care providers, like nurses, can be a support to Black men to assist with trust building among health care, collaborate from a multidisciplinary approach and be the liaison from community to primary care and multidisciplinary health teams. Community nurses can be the leaders in this area as case managers or care managers for Black men living in low-income or who have housing instability or working with re-entry programs to support Black men with getting their health care needs met. The community health providers could also focus on policy work regarding more affordable housing, as the participant, Ray, stated “housing is health”. Also needed are more seamless processes with transitions of care from those who are newly released, or with complex health conditions, and or with substance misuse and with housing instability.

Chapter 5

Conclusions & Implications for Practice, Policy & Research

Chapter five is a summarization of the dissertation purpose, review of the gaps in the literature which supported the need of this study, discussion of the findings to address the gaps and further identification of strengths and limitations of the study. The chapter ends with conclusions and recommendations for further practice, policy, and research. First the purpose of the dissertation will be presented.

Purpose of Dissertation

The purpose of the qualitative study was to further understand the social phenomenon of social determinants of health and racism among low-income middle-aged and older Black American men with complex chronic health conditions (Marshall & Rossman, 2011). The rising issues of chronic illness in the U.S., which is further complicated by health disparities among marginalized populations, requires further examination as social determinants of health and racism contributes to premature morbidity and mortality for Black Americans (Quinones et al., 2019; Buchanan et al., 2018; Gee & Ford, 2011; Noonan et al., 2016; Krieger, 2014). As populations live longer and minority groups increase in the U.S., chronic disease increases with the average person by midlife having at least one chronic condition (Raghupathi & Raghupathi, 2018). Persons of color are more likely to develop chronic disease before midlife and have more chronic conditions than their White counterparts by middle age (Quinones et al., 2019; Buchanan et al., 2018; Cunningham et al., 2017; Harris & Wallace, 2012).

Social determinants of health, racism, social stratification, structural racism and discrimination have all been shown to contribute to early exposures to stress where allostatic loads promote ongoing inflammatory responses leading to chronic disease (Nazroo & Williams, 2011; Barr, 2014; Shaw et al., 2014; Gee & Ford, 2011; Brunner & Marmot, 2011). Black Americans are less likely to follow up with healthcare providers for collaborative care to assure symptom management and increased quality of life (Noonan et al., 2016; Adebayo et al., 2019; Buchanan et al., 2018; Abramson et al., 2015; Collins & Rochert, 2016).

The disparity of Black versus White American health has been well documented. Black Americans have premature morbidity and mortality compared to their White counterparts, but Black men have the worst health outcomes and premature mortality rates from violence to complex health conditions of any other sex or race/ethnicity. Since Black men have greater rates of complex health at earlier ages, exposures to violence through racial trauma from ongoing exposures to racism, their mental and physical health are compromised. The I attempted to answer the aims since there is minimal research addressing middle aged and older, low-income Black men's health with multimorbidity from a critical race approach. Critical race theory (CRT) was the guiding lens for the entire dissertation process.

Research questions

The following research questions were addressed by each participant regarding how the participants: 1) understand and perceive their chronic health conditions; 2) manage their symptoms for quality of life and 3) short and long-term health planning through a critical race approach. According to Creswell (2007) the use of CRT in research upholds the investigator to spearhead racism and race in all aspects of the research and to tackle conventional worldviews and research work (Delgado & Stefancic, 2017).

The dissertation committee and I collaboratively worked together to interpret and further understand the phenomena collected as it related to the interplay between the narrative meanings the participants shared during the interviews and the myriad of social contexts of the participants (Ormston, et al., 2014; Erickson, 2018; Chase, 2018).

Gaps in the Literature

The gaps in the literature were identified in chapters one, two and three of the dissertation and will be reviewed and addressed based on the gathered date from the study. First, chapter one focused on use of the critical race theory (CRT) in nursing research to further gain understanding on modern racial phenomenon, challenge racial hierarchies and increase the vocabulary of complicated racial concepts. The disciplines of public health, medicine, sociology, and psychology have been prioritizing further research about the impact disparities have on Black American health. The discipline of public health has demonstrated the use of CRT to examine these disparities (Dubbin et al., 2017).

Nursing research has used CRT within research investigations of academia regarding faculty of color within nursing education but has not used the theory to examine other areas of nursing science and practice (Hall & Carlson, 2016; Beard & Wrenethra, 2016; Hall & Fields, 2013). Critical race theory is not like most theories but rather a dynamic philosophy to guide those who use its framework in their work (Delgado & Steffancic, 2017). Therefore, the use of CRT provided a guiding philosophical lens and analytical tool for me to conduct the research study and investigation on how racism impacts middle aged and older Black American men who are low-income with complex chronic health conditions (Solorzano et al., 2000; Ford & Airhihenbuwa, 2010). The use of critical race theory (CRT) in the study increased the knowledge and science in how the profession of nursing through a multidisciplinary approach to provide a more emancipatory approach to care for Black American men (Wesp et al., 2018).

Additional gaps in the literature exist among low-income, middle aged and older Black American men with multiple chronic conditions, since most studies examined in the literature review, have explored Black Americans with only one or two chronic conditions. This study examined Black men with three or more chronic health conditions as more health conditions can be challenging to manage and live with comfortably. Furthermore, most Black Americans have multimorbidity by midlife, therefore the exploration their health perceptions about their disease complexity, chronicity, illness trajectory, and symptom management from a nursing perspective was necessary to increase better health outcomes and quality of life for this population.

Semi-structured interviews were conducted and was integral to understand the lives of the Black American's lived experiences along with the application of CRT. The interviews created rich narrative data full of breadth and depth, framed a critical discourse from the voices of the participants and provided insights for emancipatory purposes. (Marshall & Rossman, 2011). The use of critical discourse analysis created a theoretical focus on issues of power and resources that are unevenly distributed across both dominant and marginalized populations, leading to premature morbidity, mortality, and low quality of life for Black American men (Marshall & Rossman, 2011)

The findings have provided new information as well as validated previous knowledge in the literature with the practice and utilization of CRT as the guiding theoretical lens and analytical tool. New insights to nursing science was accomplished through the use of the application of CRT throughout the entire dissertation by centering the narrative around the participants' shared experiences in living with multi-morbidity, experiencing symptoms, and managing their health and lives while always living with racism. The following will discuss how the findings helped validate some current findings as well as provide new knowledge to fill the gaps within the literature.

Addressing the Gaps in the Literature through the Findings

Understanding and perceptions of multiple comorbidity

The first major finding of this research is most of the participants were not aware they had chronic health conditions. Few knew that their cardiovascular diseases could become serious if they did not make health changes but only because they were told they could have a stroke or heart attack. Many of the men did not know about the progression of their diseases but did know that taking their medications, seeing their doctor or health care provider was important. Due to COVID 19 during the study, many had not seen their health care provider but were in communication with them via phone calls with them.

A conclusion that can be drawn from this finding is that the men did not receive information about their condition, or perhaps forgot what education they received with the initial diagnosis or did not understand the information that they were given. Health literacy should be considered as a barrier for this population as it is prevalent in all health care settings. Another reason for the lack of knowledge or perceptions of the seriousness of their health conditions could be the mistrust Black Americans have historically experienced of racial trauma from the U.S. health care system.

Symptom management for Quality of Life

The second major finding from the study is that all the participants reported managing either their symptoms or diseases daily through medications or alternative therapies. The men with significant symptoms like dyspnea or angina reported daily intake of the prescribed medications to use as needed with symptoms. Those with hypertension and/or diabetes could not always distinguish between the symptoms of headache, lethargy, vision changes, lightheadedness and would try to treat one at a time until the symptoms were relieved. Most participants reported QoL= “6” when initially asked. Those that rated their quality of life lower than six were either very stressed with housing instability, unemployment, unmanaged symptoms and or frustration with their health care providers due to discrimination or racism. This finding was not surprising to me considering most of the participants did not have a clear understanding of their health conditions, symptoms to be aware of, and the complexity of the multiple diagnoses.

In addition to addressing the questions of the study, it was clear that the mental health of these men has been impacted from their lived experiences as it was the third most reported health condition by the participants. Their mental and emotional health became even more challenging and prevalent during COVID, with increased isolation and stress. Men that were housing compromised, unemployed, or recently released from prison, or reported a recent loss of a loved-one, other social factors of racism with the death of George Floyd and misinformation about COVID and the vaccine, expressed the most stress. With the increased stress and isolation, these men reported: 1) using alcohol or illicit drugs more; 2) calling their family or friends more frequently; 3) reaching out to their pastors at church with a some praying to God. The more serious the symptoms, the more likely the men would be seen for emergency care that included cardiopulmonary issues, heroin overdose, car accident from drinking and driving, alcohol intoxication with escalating mental health issues was shared by some of the participants.

Some of the men disclosed other stressors that involved not feeling safe there they lived. They either experienced explicit frequent racism either daily to several times a week, felt the crime and violence was increasing where they lived and did not feel comfortable even going outside. Participants that had lived in the location of the study felt that racism and safety in the city was getting worse since they migrated 20-30 years ago, further impacting their mental health.

Although, not always able to correctly identify symptoms and how to treat them, it can be concluded that the participants recognized when they were uncomfortable, or their symptoms were causing enough concern they attempted to treat them. Some men with only hypertension stated that if they don't take their blood pressure medications, they will have a headache. A few men with diabetes stated if they eat too much, they might become tired and if they can, check their blood sugars. One man reported taking an additional unprescribed Metformin if he consumed a lot of sweets. Most of the men reported they know they must take their medications daily to maintain their health or to get better. Some men stated that they were trying to lose weight and eat better so they didn't have their diseases anymore and not have to take medications any more, which several men reported they disliked, which is supported in the literature. One participant reported he has several medical and mental health diagnoses and stopped taking his medications eight months prior to the interview because he didn't think he needed them anymore but stated he does touch base with his mental health provider if needed.

Almost all the men except a few have access to health care through Medicaid and have a primary or specialist they see on a frequent basis. The average frequency of participants who reported seeing their health care providers was every three to four months. Most felt comfortable calling their doctor with any concerns, but a few did not trust their providers based on discriminatory encounters with them. This finding was new based on the literature review with the higher frequency of health care follow up but was not an unexpected finding considering the abundance of health care providers within the county of the study and with increased, complex morbidity of the participants.

Short and Long-Term Health Planning

The third significant finding of the research addresses the participants' short- and long-term health planning. Initially the men did not understand what short-term health planning was until the I further explained what it was. After verbalizing understanding, some of the participants reported losing weight, trying to get a job or disability income, continue taking medications, eating healthy, managing stress with exercise, deep breathing, resting and other alternative therapies to manage their chronic pain. Most of the participants understood long-term health planning immediately and shared being closer to family to help them, going on trips, trying to live another five to ten years, move to a safer area, talk to their doctors about the progression of their illnesses and family about their wishes with end-of-life planning.

Almost all the men knew what a power of attorney for health care (POAHC) was and several already had them in place if they were in their upper 50's or older and several men were interested in filling one out so their wishes would be met when they couldn't make them anymore. Almost all the participants stated they wanted honest communication from their doctors or health care provider when they are declining with a few men requesting their doctors inform them "in words they understand."

Most of the men want to be cared for by family but if that was n.ot an option or if it burdened their family too much, they would want hospice, in home nursing care services, or a few would consider a nursing home, with one man stating "that way I won't be alone." Losing their independence was a huge concern for the participants as they aged. With health issues progressing as they grow older, most have a preference and goal to remain independent as long as possible. Independence of their health and daily activities is prevalent and supported in literature. A few men reported wanting everything done until there was “no hope” was also stated as a long-term health goal.

The finding of not understanding short term goals was initially surprising for me but after ongoing reflexivity and reflection it was concluded not knowing or initially being able to state short term goals was not unusual. The participants live at times on a day-by-day basis and perhaps reflecting on short term goals is not a priority or concern for them to be structured with a shorter timeframe to accomplish personal goals. Long-term goals are far enough away to be hopeful, plan and less daily pressure to meet and more realistic for the participants. Although it was clear to the researcher based on the stories the men shared from earlier in their lives to the time so of middle aged and older, they had short term goals that overall impacted their health and lives, all the men migrating to the location of the study for a better life, displaying their first actionable resistance to the dominant culture of racial violence.

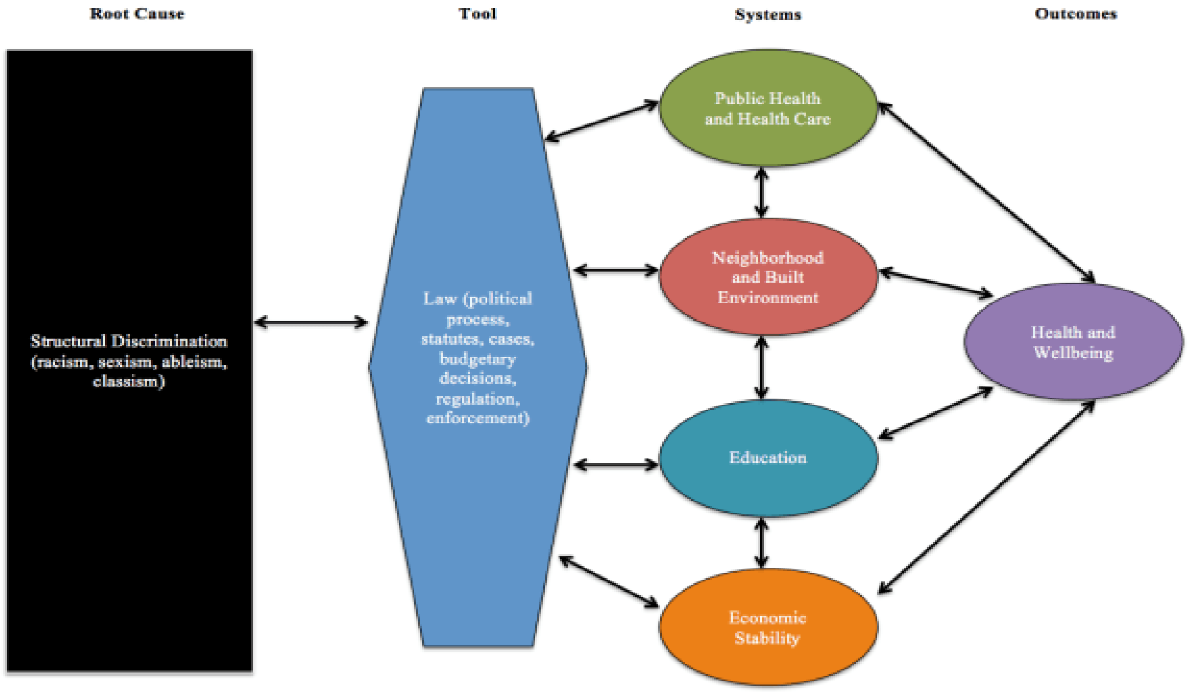
The findings from the long-term health planning from the participants contributed to new information for the literature. Living as a nurse in the resource rich county where the study was conducted, I was not astonished by how many participants had health care providers in place and received formal support for their health care conditions. The level of access to health care through social services to several subspecialists and mental health services, compared to other counties in the Midwest state. The finding that several men knew what a POAHC was either by having the document in place or was interested in more information to put the document in place, did surprise me since most of the literature supports Black men’s resistance to end of life care planning. It can be concluded that the health care system of the location of the study is addressing end of life choice for low-income Black men but further research in this area to understand this new phenomenon would be advised.

Several men also received community support from either case managers or community nurses several times a month for health care and mental support. Case management for persons with complex, severe mental health illnesses is a common benefit throughout the county. Comprehensive community services (CCS) and community service program (CSP) are voluntary community-based programs funded by the Midwest state and operated by the county department of human resources (Dane County Department of Human Services, 2023).

The two overarching themes of this study were resiliency through resistance of oppression and racism and persistence for quality of life. All the men shared how racism and oppression has impacted them, increasing their risks for social determinants of health (SDoH) further leading them to premature complex morbidity. According to Yearby (2020), racism is a root cause for SDOH that permeates for populations of color. Persons of color suffer with significant SDoH compared to their White counterparts (See Figure 3. Revised SDOH Framework) by Yearby, R. (2020).

As the literature review stated in chapters one and two, racism has correlated with poor health outcomes stemming even epigenetically. Racial barriers persist in how the U.S. governs with laws and policies that trickles into all formal and informal social structures. This can be seen from policing which the participants personally have experienced to the social brutalities against Black American men during this dissertation and even impacted one participant’s cardiac health after the death of George Floyd in the spring 2020. Through ongoing resistance of the social racist culture, the participants have found refuge with family, spiritual life, and formal support of health care support, although, some reported their discriminatory or racist encounters with their health care providers but wanted to continue to pursue health care support.

Figure 3. Revised SDOH Framework by Yearby, R. (2020).



Revised SDOH Framework created by Ruqaiijah Yearby (2020)

With the average age of the men in this study being 56.5 years of age and most of them identifying four or more chronic conditions to manage and live with, it is clear how earlier burdens of structural racism has pre-disposed them to complex health conditions. Through the impact of a lifetime of racial trauma and further oppressive intersecting identifies of low-income, identifying as Black American man, and living with complex chronic disease, has impacted their quality of life all differently based on each circumstance. Several men shared how they have had friends and family die from violence to poor health but through their earlier in life goals to resist their living situation and move to another area for a better life, demonstrated each participant's resiliency. Their persistence for quality of life has supported each man's journey to midlife with goals to grow old on their terms.

Contributions to the Literature

The findings of the study provided new knowledge from the original identified gaps in the literature. Using a critical social theory in nursing research is important to utilize as populations are growing diverse and the unjust social challenges that continue to increase among these populations from sexism, racism, ableism, to classism. Populations struggle unjustly from exploitive and oppressive actions, policy and laws create living conditions that impact their health and quality of life. This can become even more challenging when identifying with several entities, which can further oppress a person, or the concept of intersectionality, which is also a consideration for those who are marginalized. This study included Black, low-income men, where they self-reported more identities such as being divorced, a father, homeless, a previous criminal record, unemployed, which further contributed to the amount of social discrimination they experienced and personal stress. Further discussions of the tenets of CRT, in addition to intersectionality will be discussed.

Critical race theory, a critical social theory, focuses on several tenets which further oppress marginalized communities while Whites benefit from theses oppressions that stem from structural to implicit and explicit racism among Black or African Americans. The tenet of interest convergence from the dominant White culture who gains power by further exploiting or oppressing marginalized populations. Although extreme explicit racism is not as prevalent as it was during the Jim Crow years or mid-20th century in the U.S., persons of color continue to be routinely discriminated against in both private and public arenas where they are treated unfairly. This includes denial of jobs or loans, typically pay more for products than Whites, unjustly suspected of a criminal behavior by police or White citizens, suffer unjust police brutality, which was seen by one-third of the participants. Black men are generally imprisoned for longer periods of time and more often than Whites who commit the same crime, often live in segregated and impoverished neighborhoods often due to zoning issues of White dominant neighborhoods that exclude lower income and persons of color.

Black men often lack the opportunity for higher quality public education, further setting back opportunities for higher paying jobs. Some of the men from the study reported attaining their GED or advanced education while the majority have not attained a high school degree. Lastly, Black Americans typically receive less or inferior medical care than Whites that often ends with shorter lives (Delgado and Steffancic, 2017; Brittanica, 2023). All these factors were considered when analyzing and reflecting critically on the data and it was clear and with future research, policy and health care.

The past and current health care experiences have made many Black men hesitant to seek health care, which has been supported in the literature. The participants that have support within health care found it earlier in their life when their health was impacting their lives. With most men having four or more reported health conditions and the average age of the men from this study being 56.5 years was not surprising based on what the literature has found. Cardiovascular disease, particularly hypertension (HTN) was the most reported diagnosis. Chronic pain was second and mental health issues of either depression, anxiety or bipolar was the third most reported chronic condition. The reports of chronic pain and mental health was unexpected but after reflecting and analyzing the data based on the consequences of racism throughout their lives of violence and laborious jobs, became more understandable.

Few men had their chronic pain managed pharmacologically but most reported using over the counter medications or home remedies with some seeking physical therapy. This finding was not surprising based on the comments from the men regarding their attitudes towards taking medications, but one man felt differently. The participant stated he felt because of his young age (in his 40’s) and because he was Black, his provider was racist and wouldn’t treat him. Other men shared that using alcohol, or illicit drugs was a way to cope and manage their stress, mental health issues or other symptoms. Using marijuana was shared by several of the men to cope. If their mental health was complex, most had formal support in place like therapy or case workers. There were men who received community nurse support and felt that was a significant support to them not only with their health but the emotional support too. The reported use of other methods to manage symptoms, like alcohol or substance misuse, was not part of the literature review for this study but post analysis found this finding in more recent literature.

A among college aged African American college students, provided support for the independent contributions of acculturative stress and race-related stress to risking alcohol use behavior (Pittmana et al., 2019). The authors then stated that experiencing discrimination has detrimental effects on one’s ability to engage in effortful control and effective regulation of negative emotions, leading to impulsive risk-taking behaviors. The authors further reported concerns of how this problematic drinking behavior in the lifespan and the need for further models and research focusing on what motivations and experiences related to alcohol use during critical developmental periods for the Black college students. Although the study focuses on younger Black college students, racism impacts, and stress are contributions to the increased use of alcohol.

Another study focused on poverty, homelessness and social stigmas contributing to substance misuse of both illicit drug and alcohol dependence (Pear et al, 2019). The results found that adults living in poverty or low-income and with a high school degree or less were associated with higher prescription opioid overdose. Whereas poverty and unemployment were associated with increased heroin overdose in metropolitan areas. The study concluded that regardless of the urbanicity, prescription overdose had elevated rates in more economically disadvantaged zip codes and economic disadvantage played a larger role in heroin overdose in urban than rural areas, alluding to rural heroin overdoses rates to other reasons (Pear et al., 2019). Although the study did not reveal race/ethnicity, age, or sex, it perhaps can be assumed that Black Americans were part of this study based on the previous evidence provided in the literature review of the rate of unemployment, living in low-income neighborhoods and degree of education with the U.S. This finding was seen from one participant from this study where he shared that he had used heroin due to not receiving his pain prescriptions any more and overdosed.

Dr. Peter Grinspoon, a primary care provider who is a survivor of substance misuse and provides care to those with substance misuse conditions, feels SDoH contributes to racial health disparities and is a significant risk factor toward substance misuse. He stated that safety nets need to be put in place for those living with SDoH and substance misuse for their best chance of recovery. He mentioned that those with housing issues, unemployment, living in poverty, systemic racism and the effects of incarceration are some of the high-risk conditions for some populations (Grinspoon, 2021). Several of the participants of the study fall into these high-risk areas further supporting the narrative of the participants and the dire need for policy changes to decrease SDoH to improve health outcomes.

Recommendations

The following recommendations have been created to suggest further practice and education focus, how policy can improve the health of Black, low-income men and additional research to address some of the limitations of the study. First, how critical race theory implementation for health care educational curriculums and practice should be considered versus cultural competency training.

Practice and Education

The need to decrease structural racism in health care must be a priority. Before addressing structural racism, health care providers need to address their unconscious biases and/or racist ideologies. Nurses can be the leaders, since they make up the largest health care workforce in the U.S., but cultural competency continues to be used in health care settings and most educational curriculums. Cultural competency has been used within health care settings and curriculums but cultural safety, a nursing concept, should be implemented instead where the responsibility is on the clinician. The focus should be on the clinician or health care student to consider how racism is embedded within the health care system, and since most health care students and practitioners are White, reflecting one one's social position and any implicit biases is extremely important to provide culturally safe and respectful care to persons of color.

The overarching theory to add to cultural safety is CRT, for serious contemplation of one's position in society, its impact, and actions that can be implicit biases and discrimination. Reflexivity and reflection should be ongoing for all health professionals and could be instituted through policy change with annual diversity and inclusion training. Utilizing CRT and cultural safety should also be part of annual seminars for all health care students to help reinforce this positive action to combat racism. Acknowledging racist structure within healthcare can be a start and nursing can assist with the revolution for change. Th nursing profession, as a united front, can be the leaders to address the unethical and immoral impacts of racism and discrimination for all persons who suffer from its consequences.

Utilizing CRT tenets to assist with how care is approached, requires the ability to recognize where racism, classism, sexism, ableism intersect for patients and collaboratively with the patient and care team to assess the needs of the patients, like health literacy, consistent follow up with patients with complex morbidity and education and support within their communities to build trust and avoid medically acute crises through more upstream approaches. The men from this study valued the support of community nurses, who can work collaboratively from a multidisciplinary approach to help build trust among Black men earlier in all communities but especially among the those who are homeless, recently released from prison and needing support. The practice and further education recommendations are further explained in a manuscript, see appendix c.

Policy

The second recommendation would be increased community nursing capacity to enhance continuity of care not only from hospital discharges but after people are released from prison, for those who are housing compromised and those with complex chronic health conditions and or mental health conditions, including substance misuse. The funding for increased capacity for those who are very vulnerable to poor health care outcomes, should come from increased benefits from Medicaid or county funding through health and human services. The Midwest state that the study was conducted in did not expand its Medicaid benefits under the Affordable Care Act (ACA) guidelines. It is one of twelve states that did not accept the increased funding to help support state funded Medicaid benefit. The state’s legislation continues to deny acceptance of Medicaid expansion which could increase coverage for over a hundred thousand persons (Norris, 2023).

There is many skilled nursing in home care services that are reimbursable through Medicaid. These could include reimbursement for skilled assessments by nurses for high-risk populations like those who are homeless, recently released from prison, have complex health conditions including mental health. The skilled nursing visits would need to be ordered by physicians so collaboration between community nursing and primary care would require policy changes to redirect programs for community support for high-risk populations. Health clinics that accept patients with Medicaid, could have programs for community nurses to be within areas that are low-income and have open clinic hours and request orders when persons are more vulnerable or declining to receive more support based on the need. Hospitals could also be part of this program to help decrease hospitalizations and emergency department visits.

After being released from prison, another program further supports these individuals by a program with referrals to community nurse for case management for medical and mental health support. This program could be short term or longer based on the need an upstream approach to decrease medical emergencies and provide supports with a multidisciplinary approach of physicians, mental health, social work, physician assistants, nurse practitioners, etc.

Those who have severe mental illness can work with county support program case workers to provide assessments, which occurs within the county of the study. Another community support recommendation would be a direct support of a triage mental health team with mental health nurses or community nurses, therapists, and psychiatrists when clients may be escalating with their mental health symptoms. Another direct support that is now available since 2022 in the U.S. is the Suicide and Crisis Lifeline or 988, to assist with the growing, urgent mental health realities (Federal Communications Commission, 2022). According to Williams (2021), unjust police killings are damaging the mental health of Black Americans. Since the death of George Floyd in May of 2020, police violence and anti-Black racism in the U.S. This, along with the day-to-day indignities that populations of color experience, decrease their wellbeing (Williams, 2021). The narrative of the men in this study supports this finding in addition to one participant having serious physical and mental health distress requiring emergency intervention.

Lastly, palliative care with community nursing support for those with complex chronic health conditions should be expanded. Referrals for those toward the end of their illness trajectory could receive a more upstream approach for symptom management and quality of life for patients. Initiating palliative care community health support could help prevent acute exacerbations of chronic health conditions and allow patients to be at home and independent, while always being educated about their disease processes, treatment options, and symptom management to remain as independent as possible in their community until end of life. The skilled nursing visit can include medication management and adherence, ongoing assessments for patients who are not medically stable and provided mental health support. The expansion of community palliative care should be a collaboration with other disciplines and supervision of home health aides, if when clients should need this service, physical therapy, and mental health in home therapy (Wisconsin Department of Health Services, 2023). The final recommendation would be additional research that can replicate this study or advance from the new knowledge identified.

Research

Life Course Theory

Further research using additional theories with CRT would add further depth and breadth to the research study. Utilizing life course theory (LCT) or socioecological model with CRT as overarching theory are the other theories to guide researchers to further investigate the phenomenon of this study. Life course theory encompasses a multidisciplinary paradigm that focuses on person's lives, social changes and structural contexts and in particular directs attention to the powerful connection between individual's lives and the historical and socioeconomic contexts. There are six key tenets that support the LCT: 1) how the past shapes the future; 2) socio-historical and geographical location; 3) linked lives or social ties to others; 4) personal control and human agency; 5) timing of lives; and 6) variability or heterogeneity (Mitchell, 2019). The SI received some the participant's historical past as either part of the demographic or contextual information but diving deeper into the historical backgrounds of participants would provide more conclusions or rationales to their current state of being.

Historical analysis is important as it relates to an individual or event where their current situation is tentative or impermanent. Quality historical analysis requires appropriate evidence, proper assessment which involves comprehension that is related to the context in question, and then drawing sound, meaningful conclusions based on the stated evidence. Therefore, when new evidence and perspectives present themselves, it may very well alter understanding of the past (Cole et al, 2022). The SI attempted to do historical analysis when studying the data to construct meaningful conclusions, which was presented in chapter four. Using the LCT with CRT in the future can potentially unveil further phenomenon to address the aims of this study.

Community Engagement and Socioecological Model

The second research recommendation involves community engagement. Community engagement has been gaining traction in research, practice, and policy over the past several decades. Community engagement is the process of collaborative work with and through groups of people, or aggregate, with similar situations or interests, within geographic proximity to address issues affecting the well-being of the aggregate. The overall goals of community engagement are to enlist new allies and resources, build trust, create better communication, and improve health outcomes with successful projects to support ongoing collaborations (McCloskey et al., 2011).

Community engagement is rooted with the recognition that behaviors, lifestyles, and incidence of illness are shaped by physical and social environments or socioecological views. Socioecological views also consider that health inequities and inequalities have larger roots in socioeconomic conditions. Since poor health outcomes are more determined by social issues, engaging community partners with their perspectives, and understandings of community life can best approach the health concerns with a collaborative project. When health inequities stem largely from unjust, socioeconomic policy, health improvement must include the concerns of the communities who are impacted, who are largely diverse or marginalized population (McCloskey et al., 2011). Community participative research using the socioecological model will be discussed next.

Multiple factors affect health from the individual, to relationships, communities, organizations, policies, and the environment. Researchers, health professionals, community leaders consider these concepts as they intersect and impact each other using the socioecological model. The socioecological model helps to identify at different levels the individual, the interpersonal level, the community, society, policy, and environment that contribute to poor or negative health outcomes. Approaches are then developed to increase health promotion, and disease prevention among the levels with the overall goal of integrating interventions to change the physical and social environments, rather than modifying only at the individual level (Mcloskey et al, 2011). The study did address essentially the participants understanding and perspectives of their chronic health conditions, but the demographic questions, and semi-structured interview provided opportunities for the men to share how interpersonal, community, their society, some policy and their environment impacted their overall health, with racism as the root of everything. The last recommendation would be further research using the socioecological model and CRT with individual interviews and then focus groups or community participative research for their perspectives, understanding and methods to improve their well-being and overall quality of life holistically.

References

Abramson, C.M., Hashemi, M., Sanchez-Jankowski, M. (2015). Perceived discrimination in U.S. healthcare: Charting the effects of key social characteristics within and across racial groups. *Preventative Medicine Reports, 2*, 615-621. doi.org/10.1016/j.pmedr.2015.07.006.

Academy of Managed Care Pharmacy (2019). Disease management, Retrieved from https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/disease-management

Adebayo, C.T., Walker, K., Hawkins, M., Olukotun, O., Shaw, L., Parcell, E.S., Dressel, A., Luft, H., & Mkandawire-Valhmu, L. (2019). Race and blackness: A thematic review of communication challenges confronting the Black community within the U.S. health care system. *Journal of Transcultural Nursing*, 1-9, doi: 10. 1177/104365961988911

Affordable Care Act (2010). Retrieved on February 4, 2019 from https://www.healthcare.gov/glossary/affordable-care-act/

Ahmed, O.I. (2016). Disease management, case management, care management and care coordination: A framework and brief manual for care programs and staff, *Professional Case Management 21*(3), 137-146.

Alexander, M. (2012). *The new Jim Crow, mass incarceration in the age of colorblindness.* The New Press.

Allen, J.O., Griffith, D.M. & Gaines, H.C. (2013). She looks out for the meals, period: Men's perceptions of how their wives influence their eating behavior and dietary health. *Health Psychology, 32*(4), 447-455. doi: 10.1037/a0028361

Aluwihare-Samaranayake, D. (2012). Ethics in qualitative research: A view of the participants' and researchers' world from a critical standpoint. *International Journal of Qualitative Methods, 11*(2), 64-81.

American Nurses Association (2016). The nurse's role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings. Retrieved on April 22, 2020 from https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/ethics-and-human-rights-protecting-and-promoting-final-formatted-20161130.pdf

Artiga, S., Damico, A., & Garfield, R. (2015). The impact of the coverage for adults in states not expanding Medicaid by race and ethnicity, The Kaiser Commission on Medicaid and the uninsured. Retrieved on February 4, 2019 from kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-for-adults-in-the-states-not-expanding-medicaid-by-race-and-ethnicity/

Austin, J., Ocker, R., & Naro-Ware, W. (2019). Analysis of the Dane County jail population, Retrieved from file:///C:/Users/klone/Downloads/Analysis-of-the-Dane-County-Jail-Population-JFA-Institute.pdf

Barr, D.A. (2014). *Health Disparities in the United States: Social class, race, ethnicity health* (2nd ed.). Johns Hopkins University Press.

Bazargan, M., Smith, J.L, Robinson, P., Uyanne, J., Abdulrahoof, R., Chuka, C., & Assari, S. (2019). Chronic respiratory disease and health-related quality of life of African American older adults in economically disadvantaged area of Los Angeles. *International Journal* *of Environmental Research and Public Health*, *16*(1756), 3-15. https://doi.org/10.3390/ijerph16101756

Beach, M.C., Saha, S., Korthuis, P.T., Sharp, V., Cohn, J., Wilson, I.B., Eggly, S., Cooper, L.A., Roter, D., Sankar, A. & Moore, R. (2011). Patient-provider communication differs for Black compared to White HIV-infected Patients. *AIDS and Behavior, 15*(4), 805-811. doi: 10.1007/s10461-009-9664-5

Beard, K. & Wrenentha, J. (2016). Does race still matter in nursing? The narratives of African American nursing faculty members. *Nursing Outlook 64*, 583-596. https://doi.org/10.1016/j.outlook.2016.06.005

Bell, D. (1991). Racism is here to stay: Now what? *Howard Law Journal 35*, 79-93. Retrieved from file:///C:/Users/klone/Downloads/35HowardLJ79%20(1).pdf

Bell, D. (1995). Racial realism. In K. Crenshaw, N. Gotanda, P. Peller, & T. Thomas (Eds.), Critical race theory: The key writings that formed a movement (pp. 302-312). New York, NY: New Press.

Bender, M.S., Franck, L.S., Janson, S.L., Lee, K.A. (2018). Theory of symptom management. In M.J. Smith & P.R. Liehr (Eds.), Middle Range Theory for Nursing (pp. 147-177). Springer Publishing Company, LLC. doi: 10.1891/9780826159922.0008

Benjamin, E.J., Virani, S.S., Callaway, C.W., Chamberlain, A.M., Chang, A.R., Cheng, S., Chiuve, S.E., Delling, F.N., Deo, R., De Ferranti, S.D., Ferguson, J.F., Fornage, M., Gillespie, C., Isasi, C.R., Jimenez, M.C., Jordan., L.C., Judd, S.E., Lacklan, D., Lichtman, J.H. . . . Munter, P. (2018). Heart disease and stroke statistics-2018 update: A report from American Heart Association. *Circulation, 137* (12), e67-e492.

doi: 10.1161/CIR.0000000000000558

Best, A.L., Fletcher, F.E., Kadono, M., & Warren, R.C. (2021). Institutional Distrust among African Americans and Building Trustworthiness in the COVID-19 Response: Implications for Ethical Public Health Practice, *Journal of Health Care for Poor & Underserved 32*(1), 90–98. doi:10.1353/hpu.2021.0010.z

Bloomberg, L.D. & Volpe, M. (2008). *Completing Your Qualitative Dissertation: A roadmap from beginning to end*. Sage Publications, Inc.

Boucher, N.A., Guadalupe, E., Lara, L., Alejandro, M. (2014). Health care and end-of-life decisions: Community engagement with adults in east Harlem. *Journal of Community Health, 39*, 1032-39. doi:10.1007/s10900-014-9929-4

Boucher, N.A., Raghaven, M., Smith, A., Arnold, R., Johnson, K. (2016). Palliative Care in the African American Community # 204. *Journal of Palliative Medicine, 19*(2). doi: 10.1089/jpm.2015.0523

Boyd, E.L., Taylor, S.T., Shimp, L.A., Selmer, E.R. (2000). An assessment of home remedy use of African Americans. *Journal of the National Medical Association, 92*(7), 341-353.

Brender, J.D., Maantay, J.A., & Chakraborty, J. (2011). Residential proximity to environmental hazards and adverse health outcomes. *American Journal of Public Health, 101*(Suppl 1), S37-S52. doi: 10.2105/AJPH.2011.300183

Britannica (2021). What is critical race theory? *Encyclopedia Britannica*. Retrieved from https://www.britannica.com/question/What-is-critical-race-theory

Brunner, E. & Marmot, M. (2011). Social organization, stress and health. In M. Marmot & R.G.

Wilkinson (Eds), *Social determinants of health* (2nd ed., pp. 6-30). Oxford University Press.

Buchanan, D., Gubrium, A., Scott, L., & Douglas, H. (2018). The cascade of social determinants of health in producing chronic disease in low-income African American men. *International Journal of Qualitative Studies of Health and Well-Being, 13*(1549930), 1-12. doi/org/1080/17482631.2018.1549920

Butina, M. (2015). A narrative approach to qualitative inquiry. *Clinical Laboratory Science, 28*(3), 190-196.

Carter, N., Bryant-Lukosius, D., DiCensco, Blythe, J. & Neville, A.J. (2014). The use of triangulation in qualitative research. *Oncology Nurse Forum, 41*(5), 545-547. doi: 10.1188/14.ONF.545-547

Cary, M.P. Hill, L.K., Walker, J. Thorpe, R. Whitfield, K.E. (2015). Psychosocial factors associated with functional limitations among middle-aged and older African American men, *The Gerontologist*, *55*(Suppl_2), 761.

CDC (2017). African American health: Creating equal opportunities for health. Retrieved from https://www.cdc.gov/vitalsigns/aahealth/index.html

CDC (2018). Give peace of mind: Advanced care planning, Retrieved from www.cdc.gov/aging/advancecareplanning/index.htm

CDC (2019). Disability and health U.S. State profile information for Wisconsin (Adults 18+ years of age). Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/wisconsin.html

CDC (2019). Social determinants of health. Retrieved from https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#what-are-social-determinants

CDC (2020). Coronavirus Disease 2019: Groups at higher risk for severe disease. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-p0risk.html

Centers for Medicaid and Medicare (2016). Advanced care planning. Retrieved from www.medicare.gov/coverage/advance-care-planning

Chatters, L.M., Taylor, H.O., & Taylor, R.J. (2021). Racism and the life course: Social and Health equity for Black American older adults, *Public Policy & Aging Report 31*(4), 113-118. doi: https://doi.org/10.1093/ppar/prab018

Chen, R.V. (2014). Racial/ethnic health disparities in chronic disease interventions and services across socio-ecological model (Doctoral dissertation). Available from ProQuest Dissertations and Theses databases (UMI No. 3631720).

Christian, M., Seamster, L., & Ray, V. (2019). New Directions in Critical Race Theory and Sociology: Racism, White Supremacy, and Resistance, *American Behavioral Scientist 63*(13), 1731-1740. doi: 10.1177.0002764219842623

Christian, M, Seamster, L. & Ray, V. (2021). Critical Race Theory and Empirical Sociology, *American Behavioral Scientist 65*(18), 1019-1026. doi: 10.1177.0002764219859646

Clay, O.J., Perkins, M., Wallace, G., Crowe, Sawyer, P., & Brown, C.J. (2018). Associations of multimorbid medical conditions and health-related quality of life among older African American men. *Journals of Gerontology: Psychological Sciences*, *73*(2), 258-266. doi:10. 1093/geronb/gbx090

Cole, S, Breuer, K., Palmer, S.W., Blakeslee, B. (2022). *How history is made: A student's guide to reading, writing, and thinking in the discipline.* Arlington, TX: Mavs Open Press file:///C:/Users/klone/Downloads/How-History-is-Made-A-Students-Guide-to-Reading-Writing-and-Thinking-in-the-Discipline-1676563228.pdf

Collins, P. H. & Bilge, S. (2017). *Intersectionality*. Polity Press.

Collins, C. & Rochert, A. (2016). Promoting self-management and patient empowerment in primary care. *Primary Care in Practice-Integration is Needed*, 27-42. doi.org/10.5772/62763

COWS Building a Higher Road (2017). Wisconsin's extreme racial disparity: Vast chasm separates Whites and African Americans in the state. Retrieved from https://www.cows.org/_data/documents/1816.pdf

County Health Rankings, 2023. Retrieved from https://www.countyhealthrankings.org/

Crenshaw, K.W. (2011). Twenty years of critical race theory: Looking back to move forward. *Connecticut Law Review 43*(5). Retrieved from http://shain003.grads.digitalodu.com/blog/wp-content/uploads/2014/09/Twenty-Years-of-Critical-Race-Theory-Looking-Back-to-Move-Forward.pdf

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five approaches,* (3rd ed.). Sage Publications, Inc.

Creswell, J.W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches* (3rd ed.). Sage Publications, Inc.

Cuevas, A.G., Dawson, B.A., & Williams, D.R. (2016). Race and skin color in Latino Health: A systematic review. *American Journal of Public Health, 106*(12); 2131-2136. doi: 10.2105/AJPH.2016.303452

Cunningham, T.J., Croft, J.B., Liu, Y., Lu, H., Eke, P.I., & Giles, W.H. (2017). Vital signs:

Racial disparities in Age-specific mortality among Black or African Americans-United States, 1999-2015. *Department of Health and Human Services/Centers for Disease Control and Prevention*, *66*(17); 444-456.

Dabble, L., Trocki, K.F., Salcedo, B., Walker, P.C. & Korcha, K.C. (2015). Conducting qualitative interviews by telephone: Lessons learned from a study of alcohol use among sexual minority and heterosexual women. *Qualitative Social Work, 15*(1), 118-130. doi:10.1177/1473325015585613

DATAUSA, N.D. Dane County, Wisconsin: Population and Diversity. Retrieved from https://datausa.io/profile/geo/dane-county-wi/#:~:text=In%202020%2C%20there%20were%2013.3%20times%20more%20White,the%20second%20and%20third%20most%20common%20ethnic%20groups.

Dane County Department of Human Services (2023). Retrieved from https://danecountyhumanservices.org/Behavioral-Health/Comprehensive-Community-Services#:~:text=In%20Dane%20County%2C%20Comprehensive%20Community%20Services%20%28CCS%29%20is,offers%20a%20wide%20array%20of%20psychosocial%20rehabilitation%20services

Dedoose (2019). UCLA's Center for Culture and Health. Retrieved from www.dedoose.com

Delgado, R., & Stefancic, J. (2017). *Critical race theory: An introduction* (3rd ed.). University Press.

Desilver, D., Lipka, M. & Fahmy, D. (2020). Ten things we know about race and policing in the U.S., Pew Research Center. Retrieved from on July 6, 2020 https://www.pewresearch.org/fact-tank/2020/06/03/10-things-we-know-about-race-and-policing-in-the-u-s/

DiAngelo, R. (2018). *White fragility: Why it's so hard for white people to talk about racism.* Beacon Press Books.

Dickson, V.V., McCarthy, M.M., Howe, A., Schipper, J., & Katz, S.M. (2013). Sociocultural influences on heart failure self-care among an ethnic minority Black population. *Journal of Cardiovascular Nursing, 28*(2), 111-118. doi:10.1097/JCN.ObO13e31823db328

Dictionary.com (2023). Retrieved from https://www.dictionary.com/browse/persist

Donner, J.K. & Ladson-Billings, G. (2018). Critical race theory and the post racial imaginary, In N.K. Denzin & Y.S. Lincoln (5th ed.). *The Sage Handbook of Qualitative Research* (p. 202). Sage Publications, Inc.

Dubbin, L., McLemore, & Shim, J.K. (2017). Illness narratives of African Americans living with coronary heart disease: A critical interactionist analysis. *Qualitative Health Research, 27*(4), 497-508. doi: 10.1177/104973231664519

Erickson, F. (2018). A history of qualitative inquiry in social and educational research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The sage handbook of qualitative research* (pp. 36-65). Sage Publications, Inc.

Esiaka, D., Naemi, P., Kuofie, A., & Hess, R. (2019). General well-being of adult Black males with chronic illness. *Gerontology and Geriatric Medicine, 5*, 1-8. doi: 10.1177/2333721419855664

Evans, K.M., Lewis, M.J., & Hudson, S.V. (2012). The role of health literacy on African American and Hispanic/Latino perspectives on cancer clinical trials. *Journal of Cancer*

Education, 27(2), 299-305. doi: 10. 1007/s13187-011-0300-1

Feagan, J. (2000). *Racist America: Roots, current realities and future reparations*. Routledge.

Feagin, J. & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Sciences & Medicine*, *103*, 7-14. doi.org/10.1016/j.socscimed.2013.006

Federal Communications Commission (2022). 988 Suicide and Crisis Lifeline. Retrieved from https://www.fcc.gov/988-suicide-and-crisis-lifeline

Flegal, K.M., Carroll, M.D., Ogden, C.I., Curtain, L.R. (2010). Prevalence and trends in obesity among U.S. adults, 1999-2008. *Journal of the American Medical Association, 303*(3), 235-241. doi: 10.1001/jama.2009.2014

Fletcher, S.A., Marchese, M., Cole, A.P., Mahal, A.B., Friedlander, A.D., Krimphove, M., Kilbridge, K.L., Lipsitz, S.R., Nguyen, P.L., Choueiri, T.K., Kibel, A.S., & Trinh, Q.D. (2020). Graphic distribution of racial differences in prostate cancer mortality. JAMA Network Open, 3(3), 1-10. doi:10.1001/jamanetworkopen.2020.1839

Fontemont, K., Semega, J., Kollar, M. (2018). Income and poverty in the United States: 2017, Retrieved from https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-263.pdf

Ford, C. & Airhihenbuwa, C. (2010a). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health, 100*(S1); S30-S35. doi: 10.2105/AJPH.2009.171058

Ford, C. & Airhihenbuwa, C. (2010b). Critical race theory, race equity, and public health: Toward antiracism praxis, *American Journal of Public Health, 100*(S1); S30-S35. doi: 10.2105/AJPH.2009.171058

Funk, C. (2022). Black Americans' views about health disparities, experiences with health care, Retrieved from https://www.pewresearch.org/science/2022/04/07/black-americans-views-about-health-disparities-experiences-with-health-care/

Garland, K.D. (2014). Attitudes, beliefs, and knowledge of type 2 diabetes self-management among middle-aged and older African Americans, (Publication No. 3621624) [Doctoral Dissertation, Walden University]. ProQuest Dissertations Publishing.

Gaskin, D.J., Thorpe Jr., R.J., McGinty, E.E., Bower, K., Rohde, C., Hunter, J.H., LaVeist, T.A., & Dubay, L. (2014). Disparities in diabetes: The nexus of race, poverty, and Place. *American Journal of Public Health, 104*(11); 2147-2155. doi: 10.2105/AJPH.2013.301420

Gee, G.C. & Ford, C. (2011). Structural racism and health inequities. *Du Bois Review, 8*(1), 115-132. doi: 10.1017/S1742058X11000130

Glymour, M.M., Avendano, M., Kawachi, I. (2014). *Socioeconomic status and health, social Epidemiology* (2nd ed.). Oxford University Press. Oxford University Press.

Grady, P.A. & Gough, L.L. (2018). Self-management: A comprehensive approach to Management. *American Journal of Public Health, 108*(S6), S430-S436. doi: 10.2105/AJPH.2014.302041

Graham, L., Brown-Jeffy, S., Aronson, R., Stephens, C. (2011). Critical race theory as a theoretical framework and analysis tool for population health research. *Critical Public Health, 21*(1), 81-93. doi:10.1080/09581596.2010.493173

Gramlich, J. (2022). Recent surge in U.S. drug overdose deaths has hit Black men the hardest, *Pew Research Center*, Retrieved from https://www.pewresearch.org/fact-tank/2022/01/19/recent-surge-in-u-s-drug-overdose-deaths-has-hit-black-men-the-hardest/

Greaney, A.M., Sheehy, A., Heffernan, C., Murphy, J., Mhaolrunaigh, S.N., Heffernan, E., Brown, G. (2012*)*. Research ethics application: A guide for the novice researcher. *British Journal of Nursing, 21*(1), 38-43. doi: 10.12968/bjon.2012.21.1

Oxford University Press.

Griffith, D.M., Cornish, E.K., Bergner, E.M., Bruce, M.A., & Beech, B., M. (2018). Health is the ability to manage yourself without help: How older African American men define health and successful aging. *Journals of Gerontology: Psychological Sciences, 23*(2), 240-247. doi: 10.1093/geronb/gbx075

Grinspoon, P. (2021). Poverty, homelessness, and social stigma make addiction more deadly. Retrieved from https://www.health.harvard.edu/blog/poverty-homelessness-and-social-stigma-make-addiction-more-deadly-202109282602

Hall, J & Carlson, K. (2016). Marginalization: A revisitation with integration with scholarship globalization, intersectionality, privilege, microaggressions and implicit biases. *Advances in Nursing Sciences, 39*(3), 200-215. doi: 10.1097/ANS.0000000000000123

Hall, J. & Fields, B. (2013). Continuing the conversation in nursing on race and racism. *Nursing Outlook, 61*, 164-173. http://dx.doi.org./10.1016/j.outlook.2012.11.006

Han, X., Nguyen, B.T., Drope, J., & Jemal, A. (2015). Health-related outcomes among the poor: Medicaid expansion vs. non-expansion states. *Public Library of Science ONE, 10*(12);

doi: 10.1371/journal.prone.0144429

Hall, J & Carlson, K. (2016). Marginalization: a revisitation with integration with scholarship globalization, intersectionality, privilege, microaggressions and implicit biases, *Advances in Nursing Sciences, 39*(3), 200-215. doi: 10.1097/ANS.0000000000000123

Hall, J. & Fields, B. (2013). Continuing the conversation in nursing on race and racism, *Nursing Outlook, 61,* 164-173. http://dx.doi.org./10.1016/j.outlook.2012.11.006

Harris, J.R. & Wallace, R.B. (2012). The Institute of Medicine's new report on living well with chronic illness. *Preventing Chronic Disease: Public Health Research, Practice & Policy, 9*(120126), 1-3. doi.org/10.5888/pcd.9120126

Harris, K.M., Lee, H. & Deleone, F.Y. (2010). Marriage and health in the transition to adulthood: Evidence for African Americans in add health. *Journal of Family Issues, 31*(8), 1106-1143. doi: 10.1177/0192513X10365823

Hausmann, L.R., Hannon, M.J., Kresevic, D.M., Hanusa, B.H., Kwoh, C.K., & Ibrahim, S.A. (2011). Impact of perceived discrimination in health care on patient-provider communication. *Medical Care, 49*(7), 626-633. doi: 10.1097/MLR.0b013e318215d93c

Healthy People 2020. Social determinants of health. Retrieved from www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Hernández Kent, A. (2020). Examining U.S. economic racial inequality by state. Retrieved from https://www.stlouisfed.org/publications/bridges/volume-3-2020/examining-us-economic-racial-inequality-by-state#:~:text=Wisconsin%E2%80%99s%20racial%20poverty%20gap%20was%20the%2

0largest%2C%20at,of%20Black%20people%E2%80%94a%20gap%20of%2013%20percentage%2.

Heron, M. (2018). Deaths: Leading Causes for 2016. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_06.pdf

Holt, A. (2010). Using the telephone for narrative inquiry: A research Note. *Qualitative*

Hoffman, K.M., Trawalter, S., Axt, J.R., & Oliver, M.N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296-4301. doi: 10.1073/pnas.1516047113

Research, 10, 113-121. https://doi.org/10.1177%2F1468794109348686

Horrell, L.N., Kneipp, S.M., Ahn, S., Towne Jr., S.D., Mingo, C.A., Ory, M.G., & Smith, M.L., (2017). Chronic disease self-management education courses: Utilization by low-income, middle-aged participants. *International Journal for Equity in Health, 16*(114), 3-10. doi: 10.1186/s12939-017-0604-0

Hu, J., (2007). Health-related quality of life in low-income older African Americans. *Journal of Community Health Nursing, 24*(4), 253-265. doi/10.1080/07370010701645901

Iacono, V.L., Symonds, P. & Brown, D.H.K. (2016). Skype as a qualitative tool for qualitative research interviews. *Sociological Research Online, 21*(2), 1-24. doi: 10.5153/sro.3952

Iceland, J. (2013). *Poverty in America: A handbook*, (3rd ed.). University of California Press.

Incarceration trends (2015). Retrieved from http://trends.vera.org/rates/dane-county-wi and http://trends.vera.org/rates/milwaukee-county-wi.

Irvine A. (2011). Duration, dominance and depth in telephone and face-to-face interviews: A comparative exploration. *International Journal of Qualitative Methods,10*(3),202–220. https://doi.org/10.1177%2F160940691101000302

Irvine A, Drew P, Sainsbury R. (2013). 'Am I not answering your questions properly?' Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research, 13*(1), 87–106.

Janghorban, R., Roudsari, R.L., & Taghipor, A. (2014). Skype interviewing: The new generation of online synchronous interview in qualitative research. *International journal of Qualitative Studies and Health Well-Being, 9*(10), 1-3. doi: 10. 3404/qhw.v9.2415

Jenkinson, C. (2023). Quality of life. Encyclopedia Britannica. Retrieved from https://www.britannica.com/topic/quality-of-life

Johnson, K. (2013). Racial and ethnic disparities in palliative care. *Journal of Palliative Medicine, 16*(11), 1329-1334. doi: 10.1089/jpm.2013.9468

Jones, C.P. (2000). Levels of racism: A theoretical framework and a gardener's tale. *American Journal of Public Health, 90*(8), 1212-1215. doi: 10.2105/ajph.90.8.1212

Juster, R.P. McEwen, B.S. & Lupien, S.J. (2010). Allostatic biomarkers of chronic stress and

and impact on health and cognition, *Neuroscience Behavior Review, 35*(1), 2-16. doi: 10.1016/j.neubiorev.2009.10.002

Kadam, R.A. (2017). Informed consent process: A step further towards making it meaningful! *Perspectives in Clinical Research, 8*(3), 107-112. doi: 10.4103/pic.PICR_147_16: 10.4103/pic.PICR_147_16

Kaiser Family Foundation (2022). *Poverty rate by race/ethnicity*, Retrieved from https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kaiser Family Foundation (2023). Number of deaths per 100, 000 population by race/ethnicity. Retrieved from https://www.kff.org/other/state-indicator/death-rate-by-raceethnicity/?activeTab=map&currentTimeframe=0&selectedDistributions=black&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kenton, W. (2019). Federal Poverty Level. Retrieved from on February 8, 2020 https://www.investopedia.com/terms/f/fpl.asp

Kittelson, S. M., Elie, M.C., Pennypacker (2015). Palliative Care Symptom Management, *Critical Care Nursing Clinic of North America 27*(3), 315-339. doi: 10.1016/j.cnc.2015.05.010.

Kolmar, C. (2022). The Ten Wisconsin Cities with the Largest Black Population for 2022. Retrieved from https://www.roadsnacks.net/most-african-american-cities-in wisconsin/

Krieger, N. (2014). Discrimination & Health Inequities. In L.F. Berkman, I. Kawachi & M.M. Glymour (Eds), *Social epidemiology* (2nd ed.), (pp. 63-125). Oxford University Press.

Kwate, N.O.A. (2017). The race against time: Lived time, time loss, and Black health Opportunity. *Du Bois Review, 14*(2), 497-514, doi: 10.1017/S1742058X17000145

Krieger, L. (2012). Methods for the scientific study of discrimination and health: An ecosocial Approach. *American Journal of Public Health, 105* (5), 936-945. doi: 10.2105/AJPH.2011.300544

Krieger, N. (2014). Discrimination & Health Inequities. In L.F. Berkman, I. Kawachi & M.M. Glymour (Eds), *Social epidemiology* (2nd ed., pp. 63-125). Oxford University Press.

Kutner, M., Greenberg, E., & Paulsen, C. (2006). The health literacy of America’s adults: Results from 2003 national assessment of adult literacy. *National Center for Education Statistics*. Report No.: NCES 2006-483.

Lewis, J.M., DiGiacomo, M., Currow, D.C., & Davidson, P.M. (2011). Dying in the margins: Understanding palliative care and socioeconomic deprivation in the developed world. *Journal of Pain and Symptom Management, 42*(1), 105-118. doi: 10.1016/j.jpainsymman.2010.10.265

Lewis, T. T. & Van Dyke, M.E. (2018). Discrimination and the health of African Americans: The potential importance of intersectionalities. *Association for Psychological Sciences 27*(3), 176-182. https://doi.org/10.1177/0963721418770442

Liburd, L.C., Namageyo-Funa, A., Jack Jr., L., & Gregg, E. (2004). Views from within and Beyond: Illness narratives of African American men with type 2 diabetes. *Diabetes Spectrum, 17*(4), 219-224.

Link, B.G. & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, 35*, 80-94. doi.org/2307/2626958

Lu, M.C. & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A life course Perspective. *Maternal Child Health Journal*, *7*(1), 13-30. doi: 10.1023/a:1022537516969

Lukachco, A., Hatzenbuehler, M.L., & Keyes, K.M. (2014). Structural racism and myocardial infarction in the United States. *Social Science Medicine, 103*, 42-50. doi: 10.1016/j.socscimed.2013.07.021

Malone, C., Broad, J., & Steinmetz, C. (2018). Annual Wisconsin death report, *Wisconsin Department of Health Services*, 1-31. Retrieved on April 8, 2020 from https://www.dhs.wisconsin.gov/publications/p01170-18.pdf

Macarow, A. (2015). Our Prison System Is Even More Racist Than You Think, Retrieved from https://archive.attn.com/stories/2419/racism-in-american-criminal-justice-system

Marmot, M. (2011). Introduction. In M. Marmot & R.G. Wilkinson (Eds), *Social determinants of health* (2nd ed.; p. 3). Oxford University Press.

Marshall, C & Rossman, G.B. (2011). Designing qualitative research (5th ed.). Sage.

Martin, K.D., Roter, D.L., Beach, M.C., Carson, K.A., & Cooper, L.A. (2013). Physician Communication behaviors and trust among Black and White patients with hypertension. *Medical Care, 51*(2), 151-157, doi:10. 1097/MLR.0b013e31827632a2

McEwen, B.S. & Seeman, T. (1999). Protective and damaging effects of mediators of stress. Elaborating and testing the concepts of allostasis and allostatic load. *Annals of New York Academy of Sciences, 896*, 30-47. doi: 10.1111/j.1749-6632. 1999.tb08103.x

McLoskey, D.J., McDonald, M.A., Cook, J., Heurtin-Roberts, S., Updegrove, S. Sampson, D., Gutter, S., Eder. M. (2011). Community Engagement, Retrieved from https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

McIntosh M.J. & Morse, J.M. (2015). Situating and constructing diversity in semi-structured interviews, *Global Qualitative Nursing Research*, 1-12. doi: 10.1177/2333393615597674

Medical Dictionary (2023). Retrieved from https://medical-dictionary.thefreedictionary.com/Symptoms

Merriam, S.B. & Tisdell, E.J. (2016). Qualitative research: A guide to design and Implementation, (4th ed., pp. 195-229). Jossey-Bass.

Merriam-Webster. (n.d.). Self-care. In Merriam-Webster.com dictionary. Retrieved from https://www.merriam-webster.com/dictionary/self-care

Merriam-Webster. (n.d.). Well-being. In Merriam-Webster.com dictionary. Retrievefromhttps://www.merriam-webster.com/dictionary/well-being

Mitchell, B.A. (2019). Life course theory. Retrieved from https://www.encyclopedia.com/reference/encyclopedias-almanacs-transcripts-and-maps/life-course-theory

Mingo, C.A., Smith, M.L., Ahn, S., Jiang, L., Cho, J., Towne, S.D., & Ory, M.G. (2015). Chronic disease self- management education (CDSME) program delivery among urban dwelling African Americans. *Frontiers in Public Health, 2*(174), 1-9. doi: 10.3389/fpubh.2014.00174

Moffit, K. (2015). Social stratification: Definition, theories & examples. Retrieved on March 19, 2018 from: https://study.com/academy/lesson/social-stratification-definition-theories-examples.html

Mukku, V.K., Benson, T.J., Alam, F., Richie, W.F., & Bailey, R.K. (2012). Overview of substance abuse disorders and incarceration among African American males, *Frontiers in Psychology, 3*(98); 1-5. doi: 10.3389/f.psyt.2012.00098

Murphy, S.L., Xu, J., Kochaneck, K.M., Aries, E. (2018, November). *Mortality in the United States 2017*. National Center for Health Statistics. Retrieve from https://www.cdc.gov/nchs/data/databriefs/db328-h.pdf

National Cancer Institute (N.D.). Retrieved from https://www.cancer.gov/publications/dictionaries/cancer-terms/def/symptom-management

National Guideline Clearinghouse Retrieved on 11/1/19 from www.guidline.gov

Nazroo, J.Y. & Williams, D.R. (2011). The social determinants of ethnic/racial inequalities in health. In M. Marmot & R.G. Wilkinson (Eds), *Social determinants of health* (2nd ed.; pp. 238-266). Oxford University Press.

Nellis, A. (2016). The color of justice: Racial and ethnic disparity in state prisons, The sentencing project. Retrieved from www.sentencingproject.org/publication/color-of-justice-racial-and-ethnic-disparity-in state-prisons/

Nijhawan, S. (2021). Black people incarcerated twice as much in Dane Co. than nationally, study finds. Retrieved from https://www.nbc15.com/2021/05/28/black-people-incarcerated-twice-as-much-in-dane-co-than-nationally-study-finds/https://www.oxfordlearnersdictionaries.com/us/

Noonan, A.S., Valsco-Mondragon, H.E. & Wagner, F.A. (2016). Improving the health of African Americans in the USA: An overdue opportunity for social justice. *Public Health Reviews, 37*(12); 2-20. doi: 10.1186/s40985-016-0025-4

Norris, L. (2023). Medicaid eligibility and enrollment in Wisconsin. Retrieved from https://www.healthinsurance.org/medicaid/wisconsin/#:~:text=No%20ACA%20Medicaid%20expansion%20in%20Wisconsin%2C%20but%20no,non-elderly%20adults%20with%20incomes%20under%20the%20poverty%20level

Novick, G. (2008) Is there a bias against telephone interviews in qualitative research? *Research in Nursing and Health, 31*, 391–398. doi: 10.1002/nur.20259

Nowell, L.S., Norris, J.M., White, D.E, & Moules, N.J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*, 1-13. https://doi.org/10.1177%2F1609406917733847

O’Leary, P. (2022). Lived experience: A constant companion for the social work relationship, *International Social Work, 65*(6),1075-1077. doi.org/10.1177/00208728221138677

Ormston, R., Spencer, L., Barnard, M. & Snape, D (2014). In Ritchie, J., Lewis, J., McNaughton Nicholls, C. & Ormston, R. (Eds.), *Qualitative Research Practice* (2nd ed., pp. 22). Sage Publications, Inc.

Ortman, J.M., Velkoff, V.A., & Hogan, H. (2014). An aging nation: The older population in the U.S. *Current Population Reports*, 1-28. Retrieved on February 15, 2019, from https://www.census.gov/prod/2014pubs/p25-1140.pdf

Oxford Definition, (N.D.). Retrieved from https://www.bing.com/search?q=define+disease&FORM=DCTSRC

Oxford Dictionary (2020). Retrieved from https://www.lexico.com/en/definition/epigenetics

Oxford dictionary (N.D.). Retrieved from https://www.bing.com/search?q=define+symptoms&FORM=DCTSRC

Paradis, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A, Kelaher, M. & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *Public Library of Science ONE, 10*(9), 1-48. doi: 10.1371/journal.pone.0138511

Patanwala, M., Tieu, L., Ponath, C., Guzman, D., Ritchie, C.S., Kushel, M. (2017). Physical, Psychological, Social, and Existential Symptoms in Older Homeless-Experienced Adults: An Observational Study of the Hope Home Cohort, *Journal of General Internal Medicine, 33*(5), 635-643.

Pear., V.A., Ponicki, W., R., Gaidus, A., Keyes, K.M., Martins, S.S., Fink, D.S., Rivera-Aguirre, A., Gruenewald, P.J., Cerdiá (2019). Urban-rural variation in the socioeconomic determinants of opioid overdose, Drug and Alcohol Dependence 1(195) 66-73. doi: 10.1016/j.drugalcdep.2018.11.024.

Phelan, J.C. & Link, B.G. (2015). Is racism a fundamental cause of inequities in health?

Annual Review Sociology, 41, 311-330. doi:10.1146/annurev-soc-073014-112305

Pittmana, D.M., Brooksb, J.J., Kaura, P., Obasic, E.M. (2019). The cost of minority stress: Risky alcohol use and coping motivated drinking behavior in African American College Students, *Journal of Ethnic Substance Abuse, 18*(2), 257-278. doi:10.1080/15332640.2017.1336958.

Quandt, S.A., Sandberg, J.C., Grzywacz, J.G., Altizer, A.T., & Arcury, A.T. (2015). Home remedy use among African Americans and Older White Adults. *Journal of National Medical Association, 107*(2), 121-129.

Quinones, A.R., Botoseneanu, A., Markwardt, S., Nagel, C.L., Newsom, J.T., Dorr, D.A., Allore, H.G. (2019). Racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults. *PLOS One, 14*(6), 1-13. doi.org/10.1371/journal.pone/0218462.

Raghupathi, W. & Raghupathi, V. (2018). An empirical review of chronic disease in the United States: A visual analytics approach to public health. *International Journal of Environmental Research and Public Health, 15*(431), 1-24. doi:10.3390/ijerph15030431

Ratzan, S.C. & Parker, R.M. (2000). Introduction, National Library of Medicine current bibliographies in medicine: health literacy. Bethesda, MD. *National Institutes of Health, U.S. Department of Health and Human Services.* NLB Pub. No: 2000-1

Ravenell, J.E., Johnson, Jr., W.E., Whitaker, E.E. (2006). African American men's perceptions of health: Focus group study. *Journal of National Medical Association, 98*(4), 544-550.

Renwick, T. (2015). Income and poverty data. U.S. Census Bureau. Current population survey, 1968-2015. Annual Social and Economic Supplements. Retrieved on February 1, 2019 from https://www.pdx.edu/prc/sites/www.pdx.edu.prc/files/01_Renwick_Income_Poverty.pdf

Rice, L.J., Jefferson, M., Briggs, V., Delmoor, E., Johnson, J.C., Gattoni-Celli, S., Savage, S.J., Lilly, M., Prasad, S.M., Kittles, R. & Halbert, C.H. (2017). Discordance in perceived risk and epidemiological outcomes of prostate cancer among African American men. *Preventative Medicine, 7*, 1-6. doi.org/10.1016/j.pmedr.2017.04.010

Ritchie, J, Lewis, J., McNaughton Nicholls, C., Orston R. (2014). Qualitative Research Practice: A Guide for Social Science Students and Researchers, (2nd Ed.). Sage Publications, Inc.

Robinson, M. (2023). The battle of resistance versus resilience: How to build mental toughness, Retrieved from https://itspsychology.com/resistance-vs-resilience/

Rogers, B.K., Sperry, H.A. & Levant, R.F. (2015). Masculinities among African American men: An intersectional perspective. *Psychology of Men & Masculinity, 16*(4), 416-425. doi.org/10.1037/a0039082

Ruiz, N.G., Horowitz, J.M. & Tamir, C. (2020). Many Black and Asian Americans say they have experienced racism amid the COVID-19 outbreak, Pew Research Center: Social and Demographic Trends. Retrieved on July 6, 2020 from https://www.pewsocialtrends.org/2020/07/01/many-black-and-asian-americans-say-they-have-experienced-discrimination-amid-the-covid-19-outbreak/

Saban, K.L., Matthews, H.L., DeVon, H.A., & Janusek, L.W. (2014). Epigenetics and social context: implications for disparity in cardiovascular disease. *Aging & Disease, 5*(5); 346-355. http://dx.doi.org/10.14336/AD.2014.0500346

Sargent, R. (2010). Representing prison rape: Race, masculinity, and incarceration in Donald

Goines's white man's justice, black man grief. *Multi-Ethnic Literature of the U.S., 35*(3), 131-155.

Saunders, B., Sim, J., Kingstone, T. Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quality, 52*, 1893-1907. https://doi:org/10.1007/s11135-017-0574-8

Schnitter, J., Massoglia, M., & Uggen, C. (2011). Incarceration and the health of the African American community, *Du Bois Review, 8*(1), 133-141. doi: 10.1017/S1742058X11000026

Science Dictionary (2011). Retrieved from https://www.dictionary.com/browse/symptom

Shaw, M., Dorling, D. & Smith, G.D. (2011). In M. Marmot & R.G. Wilkinson (Eds), *Social determinants of health* (2nd ed.; pp. 196-223). Oxford University Press.

Shenoy, D., Packianathan, S., Chen, A.N., & Vijayakumar, S. (2016). Do African American men need separate prostate screening guidelines? *BMC Urology, 16*(19), 1-6. DOI 10.1186/s12894-016-0137-7

Sherman, L. (2015). We've come this far by faith: Faith and spirituality as a factor to self-management of type 2 diabetes among African American men. *Journal of Social Health and Diabetes, 3*(1), 36-42.

Shiyanbola, O.O., Ward, E.C., & Brown, C.M. (2018). Utilizing the commonsense model to explore African Americans' perceptions of type 2 diabetes: A qualitative study. *PLOS One, 13*(11), 1-22, doi.org/10.1371/journal.pone.0207692

Sitgraves, C. (2008). The benefits of marriage for African American men, *Center for marriage* *and families*, 10, 1-8. Retrieved on December 12, 2019. from http://americanvalues.org/catalog/pdfs/researchbrief10.pdf

Solorzano, D., Ceja, M. & Yosso, T. (2000). Critical Race Theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *Journal of Negro Education*, *69*(1/2), 60-73.

Song, L, Hamilton, J.B. & Moore, A.D. (2012). Patient-healthcare provider communication: Perspectives of African American cancer patients. *Health Psychology*, *31*(5), 539-547. doi: 10.1037/a0025334

Sopcheck, J. (2016). Social, economic, and political issues affecting end-of-life. *Policy, Politics, and Nursing Practice*, *17*(1), 32-42. doi: 10. 1177/1527154416642664

Sturges J.E. & Hanrahan K.J. (2004). Comparing telephone and face-to-face qulitative interviewing: A Research Note. *Qualitative Research*, *4*(1), 107–118.

Sweet, L. (2002). Telephone interviewing: Is it compatible with interpretive phenomenological research? *Contemporary Nurse*, *12*(1), 58–63. doi: 10.5172/conu.12.1.58

Torrey, T. (2020). Overview of Disease Management, Retrieved from https://www.verywellhealth.com/disease-management-2615164

Thorpe, R., Fesahazion, R.G., Parker, L., Wilder, T., Rooks, R.N., Bowie, J.N., Bell, C.N., Szanton, S.L., & LaViest, L.N. (2016). Accelerated health declines of African Americans in the U.S.A. *Journal of Urban Health*, *93*(5), 808-819. doi:10.1007/s11524-016-0075-4

Underwood III, W. (2020). Racial regional variations in prostate cancer survival must be viewed in the context of overall racial disparities in prostate cancer. *JAMA Network Open, 3*(3), 1-3. doi:10.1001/jamanetworkopen.2020.1854

United Way of Dane County (2019). Journey home immobilization plan: A reset for returning citizens, 1-92. Retrieved from https://www.unitedwaydanecounty.org/wp-content/uploads/JourneyHome-MobilizationPlan-19.pdf

USA Facts (2021). Retrieved from https://usafacts.org/articles/men-die-more-often-than-women-black-men-are-the-hardest-hit/

Van de Velde, D., De Zutter, F., Satink, T., Costa, U., Janquart, S., Senn, & De Vriendt, P. (2019). Delineating the concept of self-management in chronic conditions: A concept analysis. *British Medical Journal Open, 9*(e027775). doi: 10. 1136/bmjopen-2018-027775

Vereen, L.G., Wines, L.A., Lemberger-Truelove, T., Hannon, M.D., Howard, N., Burt, I. (2017). Black existentialism: Extending the discourse on meaning and existence. *Journal of Humanist Counseling, 56,* 72-84. doi: 10.1002/johc.12045

Wade, J.C. & Rochlen, A.B. (2012). Introduction: Masculinity, identity and the health and well-being of African American men. *Psychology of Men & Masculinity, 14*(1), 1-6. doi: 10/1037/a0029612

Wesley, L. (2015). The intersection of race and gender: Teaching reformed gender ideologies to Black males in the context of hegemonic masculinity. *Journal of Black Sexuality and Relationships, 1*(4), 63-84. doi.org/10.1353/bsr.2015.0010

Wesp, L.M., Scheer, V., Ruiz, A., Walker, K., Weitzel, J., Shaw, L., Kako, P.N., & Mkandawire-Valhmu, L. (2018). An emancipatory approach to cultural competency: The application of critical race, post-colonial, and intersectionality theories. *Advanced Nursing Science, 41*(4),316-326. doi:10.1097/ANS.0000000000000230

Williams, D.R. & Cooper, L.A. (2019). Reducing racial inequalities in health: Using what we already know to take action. *International Journal of Environmental Research and Public Health, 16*(606), 1-26. doi:10.3390/ijerph16040606

Williams, D.R., & Mohammad, S.A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *International Journal of Environmental Research and Public Health*, *30,* 20-47. doi:10.1007/s10865-008-9185-0

Williams, D. (2020). Rethinking Black Families in Poverty: Postcolonial Critiques and Critical Race Possibilities, *Research Gate*, 143-164, doi:10.1163/9789004433168_008

Williams, D.R., Mohammad, S.A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Science, 1186*, 69-101. doi: 10. 1111/j.1749-6632/2009.053339x

Williams, D.R. (2021). How unjust police killings damage the mental health of Black Americans, The Harvard Gazette. Retrieved from https://news.harvard.edu/gazette/story/2021/05/how-unjust-police-killings-damage-the-mental-health-of-black-americans/

Wisconsin Health and Human Services Department (2022). Retrieved from https://dhs.wisconsin.gov/covid-19/disparities.htm#disparities

World Health Organization (2019). Retrieved from https://www.who.int/cancer/palliative/definition/en/

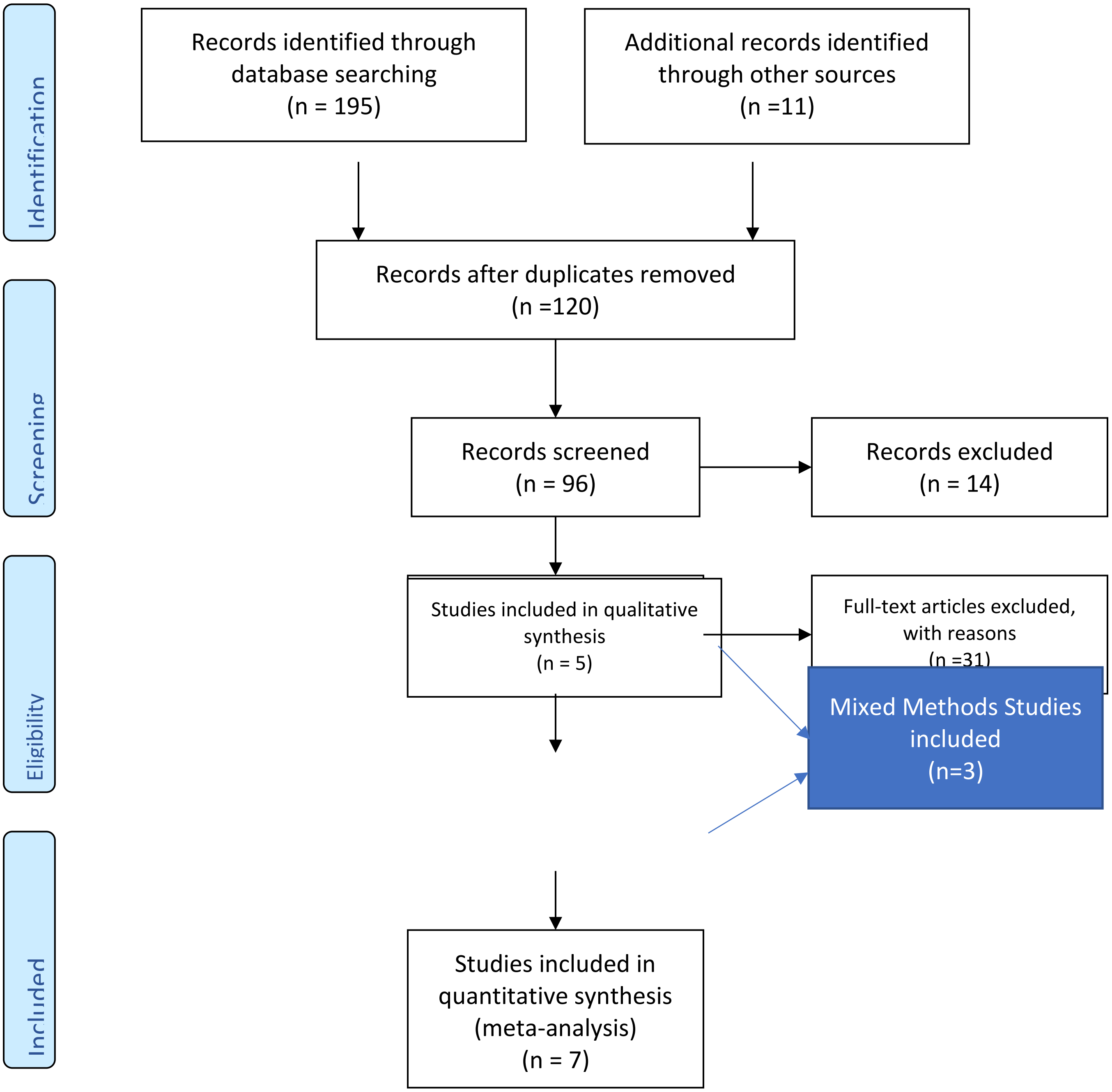
World Health Organization (2022). Retrieved from https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

Wisconsin Department of Health Services (2023). Forward Health. Retrieved from https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=29&s=2&c=362&nt=

Yearby, R. (2020). Structural racism and health disparities: Reconfiguring the social determinants of health framework to include the root cause, *Journal of Law Medicine and Ethics 48*(3). 518-526. doi: 10.1177/1073110520958876.

Appendix A.

PRISMA 2009 Flow Diagram-Literature Review



Appendix B. Literature Review Evidence Table

Quantitative

Author/Level/Location	Research Aim/Purpose	Sample	Results	Strengths/Limitations
Cary et al., (2015) Observational analytical Level 3c Baltimore, MD Nursing	Examined psychological or behavioral manifestations of resilience, few studies have focused on functional outcomes.	Using data from the Baltimore Study of Black Aging (BSBA), we examined psychosocial factors associated with functional limitations self-reported limitations in activities of daily living (ADLs)] in a sample of 141 African American (AA) men, mean age=67 (SD=9.3)	Psychosocial factors included: depression, perceived control, and social functioning. To better approximate the conceptualization of functional resilience, analyses were limited to include only AA men who reported experiencing stress. After adjusting for age, education, income, cognitive functioning, and chronic conditions, depression ($p<0.001$) predicted more limitation in functioning whereas social functioning ($p>0.04$) predicted fewer limitations in functioning is an important component of sustained functional resilience in African American men.	No guided theory was mentioned considering further analysis psychological and behavioral manifestations of resilience. A more critical lens would have been more beneficial to consider due to racism and resiliency is concept from a white dominant culture.
Esiaka et al. 2019 Level- III Location- U.S. (Psychology/Medicine)	Investigate reports of general well-being using on-line survey indicating subjective feelings of psychological well-being and distress	Cross-sectional study of older adult Black Males with presence of 1 or more chronic conditions, descriptive analysis; men age 42 yrs., 95% had >12yrs. Ed., 58% married,	Full regression model significant ($p<.001$), with self-esteem a significant indicator for well-being among Black males. Strong ethnic identity, being married, social support system = well-being. Increased coping of Black males had negative perceptions of well-being-contradictory to previous studies and active coping	Did not differentiate bx # or which chronic conditions for each responder, SES not indicated or geographic location in U.S. Not applicable to older Black males, low incentive to responders ($1.00) could have limited participation Significant correlations between social relationships, ethnic identity to increased perceptions of well-being

			($\beta=-0.41$; $\rho=0.09$) to be negatively correlated to well-being	
Rice et al., 2017 Level-Ib Location-Urban community setting city in U.S. (Psychology/Medicine)	To examine factors that are important to prostate cancer screening decisions among AA men, perceptions risks for developing prostate CA and evaluated relationship bx prostate CA risk perceptions & sociodemographic characteristics, health care experiences and knowledge & exposure health information about CA	N=198 AA men, ages 18-75 yrs., randomized study to attend risk education intervention that focused on motivational changes in diet and physical activity. 1 risk education group-integrated risk education and other- disease-specific education, mean age=48 yrs., 89%=not married, 58% less than or equal to H.S. diploma, 57% <$20,000 annual income, 64% not employed, 72% had health insurance, 29% had HTN, 13% diabetes, 35% family hx of CA	Telephone interview to self-identified participants who met inclusion criteria, answered structured survey, then invited to attend risk education sessions listed under sample details. Used descriptive statistics for all concepts of inquiry, see research aims, used bivariate statistics using chi squared tests of association to evaluate the relationship bx risk perceptions and variables, then logic regression analyses to identify factors having independent associations with perceived risk of developing prostate CA, men with income <$20,000, men unemployed and men 50 yrs. and older perceived much higher risk for development of prostate CA. Men with HTN and family hx also reported higher risk for developing prostate CA.	Only used Likert like scale to evaluate comparative risk-perception and all history collected was self-identified leading to potential inaccuracies or biases. Novel information about perceived risk of developing prostate CA among men who are most susceptible and found significant discordance bx AA men perception of developing prostate CA and epidemiological date about risk factors for disease.
Garland (2014) U.S. Public Health	Purpose: assess knowledge, attitudes and beliefs of African Americans toward type 2 diabetes, risk factors and self-management. Health belief model used	Five research questions examined type 2 diabetes related attitudes, knowledge and beliefs and knowledge on diabetes self-management and risk factors. Quantitative design	ANOVA test results indicated significant differences bx diabetes knowledge, education, family income (with a positive interaction bx education & family income) and significant differences bx perceptions of	Limitations to study were not clear, differences between genders not clear or socioeconomic status, choice of theory doesn't consider social determinants of health and racism of African Americans and more knowledge would have been gain with a mixed methods approach to go deeper into the why with the statistical data but perhaps this was limited since this

		collecting self-reported survey on 120 African Americans, ages 40-65 yrs.	health beliefs about self-management with gender and age. However, there are no statistical differences between diabetes knowledge, attitudes or between genders. Pearson product moment correlations were used to determine the strength and direction of the relationship bx health beliefs related to diabetes self-management and aga. Older African Americans with type 2 diabetes reported fewer positive beliefs about susceptibility to diabetes and negative complications with no significant findings bx age, barriers or benefits.	was a dissertation study. Also, the geographical region of where the study was conducted, was not provided.
Clay, et al., (2018) Level III (Psychology) Birmingham, AL	Assess the relationships bx categories of conditions & physical & mental health-related QoL SF-12 Used life course framework to identify populations at high risk for unequal health outcomes, framework for tracking system macro-level organizations and highlights where an intervention may be most beneficial	N=247 AA men, mean age 75 yrs., 49% lived in rural areas with multimorbidity: metabolic syndrome, kidney failure, neurological complications, COPD, and CVD.	Covariate-adjusted models revealed low education, low-income, metabolic syndrome, COPD & CVD were associated with lower scores on physical health-related QoL (p's, .05). Low-income was also associated with lower scores on mental health-related QoL.	Utilized quantitative data to examine SDOH impacts on health, chronic conditions and using a guiding theory to guide work and recommendations. Innovative approach to categorize multimorbidity with older AA men and assessed their associations with health related QoL. Income levels were not specific as they used the phrase "income difficulty". Challenging to differentiate where multimorbidity was present except for the association of COPD & CVD and QoL.
Bazargan et al., (2019) Level III Los Angeles, CA Medicine & Public Health	Investigate on whether Chrocon respiratory disease s contribute to physical & mental	N=671, AA's ≥ 65 yrs., cross-sectional community-based survey	Descriptive statistics to describe variables in sample, bivariate analysis to show	Not random sample and results can be skewed or generalized to other populations men not represented well, ¼ of

	HRQoL of older AA who live in economically disadvantaged urban areas and if effects are due to demographic factors, SES, health behaviors & comorbid medical & mental conditions.	using convenient, non-random sample, mean age 74 yrs. old, 65.2% female, lived alone, 60%, non-married, 86%, 47% reported smoking cigarettes in their lifetime, 24.3% had CRC	bivariate correlations between study variables, multivariate analysis to show 2 linear regression models separating for PCS & MCS as outcomes with results of CRC presence associated with lower PCS and MCS. AA living in economically disadvantaged urban areas with CRCs contribute to poor physical HRQoL	sample, due to cross-sectional design, no causal inferences can be made. CRC and comorbid CMCs were self-reported, air pollution was not considered in the urban area on observed relationships. Implications for further research on health and public policy in regard to CRC since most research focuses on AA CVD and how SDoH create health inequities
Hu (2007) Level-III Nursing	What is the HRQoL among low-income older AA compared to norms for the U.S. general population, 60 yrs. and older? What are the relationships among comorbid conditions, symptom distress, depression, functional status, and HRQoL among low-income older AA?	N=83 convenient sample of older AA living in subsidized housing (73% women, all below poverty line, all less 12 yrs. education, 79% had comorbidities, 53% rated health as fair to poor, age 60-90 yrs. Most had religious or spiritual affiliation No mean age listed Symptom distress scale using Likert scale, Geriatric depression scale, Instrumental Activities of Daily Living and HRQOL measured by Medical outcomes Study Short Form	Descriptive statistics IADL-6.59=mean score was most functioning independently Bivariate correlations=higher comorbidities, lower HRQoL, higher rate of symptoms, depression, low functioning of IADLs	Findings are congruent with other studies, not new information, convenient sample so some biases, not applicable to all, specific area in south east U.S., did not consider how low SES may be impacting all factors measured. Specific diseases not listed. Implications for community nursing with population, statistically supportive results.

Qualitative

Authors/Location	Research Aim	Participants	Design/Data collection Strategies	Findings	Limitations/Strenghts
Griffith et al, 2018 Nashville, TN (Public Health)	Examine how older AA men's conceptions and definitions of health and notions of successful aging are interrelated. Successful aging framework to guide study	22 AA men, ages (55-76 years); mean age 62, Annual income 36% < 19, 000 per yr., 14% bx $40-74, 999 per year, & 36% unreported	Semi-structured individual interviews	AA men operationalize notions of health into 4 elements of successful aging. 1. Absence of disease and disability 2. Ability to manage physical & cognitive functioning 3. Meaningful social engagement in life 4. Actual behavior critical aspect of how define health & concepts consistent with aging Emphasized importance of self-reliance, independence, ability to survive without help from others=hallmarks of masculinity	SES & what chronic conditions or number of chronic conditions per participants was not clear on all participants, no quotes listed in article by participants, limited to urban area in south, did not ask explicitly what successful ageing meant to them. Stayed true to conceptual model Rowe & Kahn definition of health model, utilized multiple coders, a systematic analysis for coding & criterion sampling leading to trustworthy findings
Patanwala et al., (2017) Oakland, CA Community/Public Health	To describe the prevalence of symptoms among older homeless-experienced adults, analyze factors associated with moderate–high physical symptom burden, and identify	350 homeless adults aged 50 years and older from overnight homeless shelters (n = 5), low-cost meal programs (n = 5), a recycling center, and places where unsheltered homeless adults stayed	Mixed methods Assessed physical symptoms using the Patient Health Questionnaire –15 (PHQ-15); psychological symptoms using the Center for Epidemiologic Studies	Two hundred eighty-three participants (75.6% men and 82.3% African Americans) completed symptoms interviews. Over a third (34.0%) had moderate–high physical symptom burden. The most prevalent physical symptoms were joint pain, fatigue, back pain, and	Older homeless-experienced adults exhibit a high prevalence of symptoms across multiple dimensions. To reduce suffering, clinicians should recognize the interaction between symptoms and address multiple symptom dimensions.

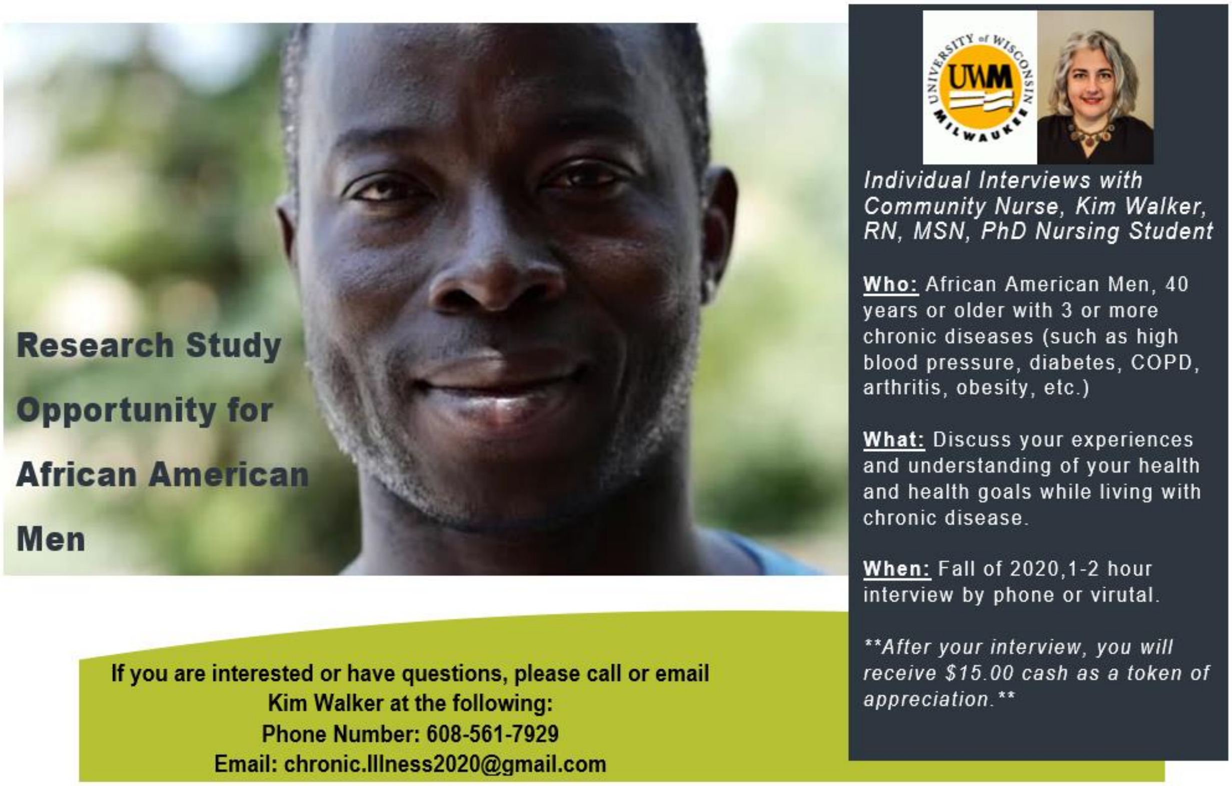
	symptom clusters		Depression Scale (CES-D), Primary Care PTSD Screen (PC-PTSD), and psychiatric section of the Addiction Severity Index (ASI); loneliness using the Three-Item Loneliness Scale; and regret using a six-item regret scale. Then interviews q 6 months	sleep trouble. Over half (57.6%) had psychological symptoms; 39.6% exhibited loneliness and 26.5% had high regret. In a multivariate model, being a woman (AOR 2.54, 95% CI 1.28–5.03), childhood abuse (AOR 1.88, 95% CI 1.00–3.50), cannabis use (AOR 2.59, 95% CI 1.38–4.89), multimorbidity (AOR 2.50, 95% CI 1.36– 4.58), anxiety (AOR 4.30, 95% CI 2.24–8.26), hallucinations (AOR 3.77, 95% CI 1.36–10.43), and loneliness (AOR 2.32, 95% CI 1.26–4.28) were associated with moderate– high physical symptom burden. We identified four symptom clusters: minimal overall (n = 129), moderate overall (n = 68), high physical and high psychological (n = 67), and high physical and low psychological (n = 17).	
Dickson et al, 2013, location not specified (Nursing)	To describe the self-care practices and sociocultural influences of self-care in ethnic, minority black population with heart failure	N=30 black patients, mean age of 62 yrs., 60 % men, 40% women, 60% single, 47 % < H.S. education, 53% unemployed,	Mixed methods, concurrent nested study where all data was collected in 1 session, semi structured interviews, standardized questionnaire for self-care-Self-care of Heart Failure Index (SCHFI) α=0.77, used theoretical	Qualitative results=used Atlas.ti version 6.0 thematic analysis, overall self-care was poor and varied in behaviors with lack of adherence to diet and symptom monitoring but good adherence to medication regimes, only 2 participants engaged in self-management of symptoms that are typically prescribed	Methodological rigor maintained thru, audit trail, periodic peer debriefing, member checking to support credibility of study, triangulation met with using mixed methods, both methods had similar, confirming results. Results were not differentiated bx men and women, 33% of participants were born outside of U.S. although most reported being in U.S. since childhood, typically other chronic diseases are accompanied

			framework naturalistic decision making	for HF pts and that self-care is influenced by cultural beliefs (spirituality=”God will provide all that is needed” & others extrinsic spirituality “doing what doctor says”, social norms drive social supports (financial & HC access) increased self-care and management of symptoms “just go to clinic”. Social support limited if they were no longer able to participate in culturally based social activities (most moderately physically impaired) and reluctant to ask for support, many limited who they confided with and men reported they carried the burden and not seek help. Quantitative results= Cronbach α= .67, .56 and .83, SPSS, 15.0 calculated the descriptive statistics, where self-care poor 60%, 97% concordance bx SCHFI scores and narrative accounts of self-care, taking medications was supported by cultural belief “essential to live a long life, conversely dietary restrictions were limited to cultural food preferences, “Island food, no good for heart but good for soul”.	with CVD within this population and could have been skewing participants reports of symptoms, self-care and perceptions.
Liburd et al., (2004). Raleigh and Greensboro, N.C.	Examine and understand the psychosocial	Quantitative study	Mixed methods	Quantitative analysis used SUDAAN software	Not many demographics for either study, older study, bit confusing to

(Public Health)	and behavioral perspectives of AA with DM2	N=2, 310 AA's answered a baseline, epidemiological survey for Project Direct; average age 57 yrs, living with DM2 for 8.5 yrs. Qualitative study Life History study: N=16, aged 39-71 yrs., and mean time of living with DM2 was for 2 yrs. Anthropological study, mean age for AA men was 54 yrs. and duration for having DM2 was 10.6 yrs.	exploratory study Survey and In-depth semi structured interviews Illness narrative framework was used to obtain insight into perceptions and experiences of individuals living with DM2	to account for the complex sampling scheme that focused on AA male adults and clinical biomarkers (A1C, LDL, cholesterol, and total cholesterol) >1/3 had A1C >10% 4/5 had A1C of 7% 1/3 had LDL >130mg/dl 44% had total cholesterol levels >200mg/dl Qualitative analysis used content analysis Most identified diet as principle reason for diabetes, some believe inherited. Majority experienced symptoms of undiagnosed DM2, many it was difficult to accept dx and medications, all indicated it was their responsibility to manage DM2, Some stated managing DM2 was stressful for them and partners, inability to perform sexually was stressful, some expressed emotional toll of depression, some felt it was a wake up call and took better care, high DM2 in AA communities suggests normative disorder, some had shame with disclosing their dx. Themes of masculinity of not wanting others to know, but those that did disclose to social supports were supported	follow and short for a mixed method study, framework was innovative to answer research purpose.

Shiyanbola et al., (2018) Midwestern State in U.S. Social & Administrative Sciences, Nursing, & Pharmacy	Conceptual framework: Common sense model of illness & self-regulation To explore the AA's perceptions of DM2 based on the commonsense model of illness and self-regulation. Phenomenology	N=40 AA men & women, ages 45-60 yrs., with DM2 for at least 1 year and take 1prescribed diabetic medication, 25 were women, with mean age of 53 yrs. 28% had HS degree, and 33% had college degree, self-reported health status was fair-43.6%., mean number of chronic diseases of each participant was 2.9 and had diabetes mean of 9.6 years.	CSM domains were explored using an exploratory descriptive qualitative approach with 6 semi-structured focus groups, qualitative content analysis was conducted NVivo 10 was used	Participants expressed historical issues in how they developed DM2 (slavery, HCP, govt', God) Then loss of autonomy (change in identity as an employee, social individual & sexual, and anger/frustration with having DM2, impacted family relations with food restrictions, fear of death and amputations and wanting to prevent children and other family from getting). Lastly, medications & faith in God, positive thinking about survival helped control DM2	Focused groups mixed genders which can skew or inhibit responses of participants, more women represented, doesn't account for lower educated, not applicable to all. Questions followed conceptual framework, excellent report of findings well organize charts and quotes from respondents.

Appendix C. Flyer for Proposed Research Study



Research Study Opportunity for African American Men

Individual Interviews with Community Nurse, Kim Walker, RN, MSN, PhD Nursing Student

Who: African American Men, 40 years or older with 3 or more chronic diseases (such as high blood pressure, diabetes, COPD, arthritis, obesity, etc.)

What: Discuss your experiences and understanding of your health and health goals while living with chronic disease.

When: Fall of 2020,1-2 hour interview by phone or virutal.

After your interview, you will receive $15.00 cash as a token of appreciation.

If you are interested or have questions, please call or email
Kim Walker at the following:
Phone Number: 608-561-7929
Email: chronic.Illness2020@gmail.com

Appendix D. Inclusion Criteria Questions

1. Age_______& DOB_______ Gender _____(must be 40 years or older at the time of the interview and identify as a male)

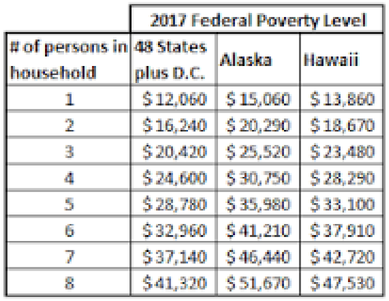
2. What ethnicity/race do you identify with: __________________ (Black or multiracial).

3. How low have lived in U.S.? ___________(since childhood to participate).

4. What is your primary language spoken, written and read? __________ (must be fluent and understand English to participate and read at a 4th grade reading level).

5. What is your annual income based on the number within your household? ___________ (must be within the Federal Poverty level listed below)

(Federal Poverty Level, Kenton, 2019)



	2017 Federal Poverty Level		
# of persons in household	48 States plus D.C.	Alaska	Hawaii
1	$ 12,060	$ 15,060	$ 13,860
2	$ 16,240	$ 20,290	$ 18,670
3	$ 20,420	$ 25,520	$ 23,480
4	$ 24,600	$ 30,750	$ 28,290
5	$ 28,780	$ 35,980	$ 33,100
6	$ 32,960	$ 41,210	$ 37,910
7	$ 37,140	$ 46,440	$ 42,720
8	$ 41,320	$ 51,670	$ 47,530

6. List 3 or more health care conditions you have had for 1 or more years (based on what patient reports, or medications patient is taking or list of medical diagnosis that potential participant provides from medical provider within the past year)
   a. ____
   b. ____
   c. ____

7. Do you make your own health care decisions? ____________ (must be own person to participate)

Appendix E. Demographic Questions.

1. Do you have access to health care services? _________ Do you have health insurance? If so, what is it? ______________
2. Do have medications you take for your chronic conditions? ________ Do you take the medications that are prescribed to you? ______If no, please explain why not? ____
   How do you get your medications (financially and delivery, pick up) ________
3. How often do you see a health care provider in a 1-year period? _________
4. Have you been to the hospital emergency room or hospitalized in the past 2 years? _____If so, for what reason? ____
5. What do you use for transportation to health care appointments and health care needs like medication or physical therapy? _____________
6. Marital status: Married, partner, widowed, divorced, single? ____________
7. What is the highest level of education you attained? __________
8. Food Security Questions (based on FoodShare from Hungercare Coalition questionnaire: responses as “often true, sometimes true or never true”
   a. Over the past 12 months, have you worried if your food would run out before you had enough money to buy more?
   b. Over the past 12 months have you run out of food and you didn’t have enough money to buy more?
9. Where do you get your food from most of time? Do you live in a food desert area? ____
10. Do finances or money play a role in how you are able to manage your healthcare needs?
11. Do you currently have housing? _______If so, what type of housing? (public housing, affordable housing)
12. Do you have any concerns about your current housing? _____ If so, what? ______Does your housing play a role in your health condition?
13. How long have you lived in the Madison, WI area? __________

14. On a scale of 1-10 with 10 being the best or greatest, how you rate your quality of life?
______

Appendix F. In-depth, Semi-structured Interview Questions.

Semi-structured Interview Guide and Sampling Plan for Individual Interviews

Interview and audio recording will continue after receiving verbal consent. Short note taking will be included during the interview and interviewer will inform participant of this.

I. Introduction and purpose of interview: I am interested in your experiences and understanding of your health and future health planning as it relates to your chronic conditions. (Research aim #1-addressing understanding and perception of complex chronic disease)

1. Tell me about your health and what you know about it. Please explain each diagnosis in how you understand it.
2. Share what chronic disease means to you.
3. How has your health changed over the years, months or weeks?
4. How do you see your health changing in the future?
5. Has your doctor or health care providers (HCP), or community supports talked to you about your chronic diseases?

II. I would like to talk about what quality of life means as it relates to the management of your chronic diseases (Research aim #2-quality of life by participant's management of his symptoms)

1. What does quality of life mean to you? What does quality of life mean while living with multiple chronic conditions?
2. What does symptom management or management of your health and your chronic diseases mean to you?
3. How do you manage your symptoms and your diseases on a daily, weekly, or monthly basis?
4. How do you feel your quality of life would be if you had your symptoms managed?
5. Has a health care provider or anyone else, discussed how you manage your diseases or symptoms from your diseases on a daily, weekly or monthly basis? Please explain.
6. How has your doctor, HCP or community helped you with your health care issues/concerns on a monthly and/or yearly basis?

I. Now I would like to talk about short- and long-term planning as it relates to your complex chronic diseases (Research aim # 3- Understanding and perceptions regarding short-term and future long term planning and goals and use of advanced directives to assist with goals to be known family, friends and healthcare teams

1. What is important to you, or your health wishes as you continue to live now and in the future with your diseases?
2. What are your short-term goals now regarding your health?
3. Have you thought about how your health will change, improve or worsen in the future? How will you prepare for that?
4. How would you like to be cared for as you progress with your illness?
5. When providing care to you, has your doctor or HCP discussed the long- term effects of your chronic diseases?
6. What do you think the role of your doctor or HCP should be as your illness deteriorates, progresses, or worsens? Are there other health care providers, like nurses, social workers or other community members you talk to about your health care concerns and short- and long-term health care planning goals?
7. How do you think you can reach these goals?
8. What kind of help do you think you will need to reach these goals?
9. Have you heard of an advanced care planning and how it can help you?
10. Has your doctor or HCP talked to you about an ACP?
11. Would you be interested in learning more about advanced care planning? (have a copy of a POAHC as a reference and if interested in more information will provide that to participant).
12. Closing: Thank the participant for time and sharing his experiences and perspectives. Share that the researcher will transcribe the audio recordings of the interview and will reach out to the participant to clarify and verify the participant’s interview, where a 2nd $5.00 gift card for their time. Then give the $15.00 cash as an appreciation for their time and sharing.

Appendix G. Research Consent Form (Bloomberg & Volpe, 2008).

UNIVERSITY of WISCONSIN
UWMILWAUKEE

College of Nursing
PART 1: Research Description

Principal Researcher: Kimberly A. Walker, MSN, RN, PhD Student
Research Title: How middle-aged and older, low-income African American men understand and manage their chronic health conditions and their short and long-term health planning for quality of life from a critical race approach.

You are invited to participate in a research study that explores how African American men understand and manage their chronic health conditions and short and long-term health planning for quality of life. Your participation requires an interview where you will be asked questions about your experiences, perspectives, and opinions about living with complex chronic disease. The duration of the interview will be approximately sixty to ninety minutes and with your permission will be audio recorded and then transcribed to capture and maintain an accurate record of the discussion. You will remain anonymous on all transcripts and data collection. This study will be conducted by the researcher, Kimberly Walker, a doctoral student, at the University of Wisconsin-Milwaukee, College of Nursing. The interview will be conducted at a time that is convenient for you and the principal researcher either by phone or virtually. Your decision to participate or not participate will not impact your relationship or services received by Kimberly Walker, as the nursing instructor for Edgewood College Nursing Students, or from her nursing students.

Risks and Benefits:

This research will hopefully contribute to understanding how African American men understand and manage their chronic health conditions and short and long-term health planning to enhance quality of life to improve their chronic health and quality of life. By participating in this study, there will be no negative outcomes as it relates to receiving future healthcare by your healthcare provider or by the Edgewood Nursing Students or their instructor, who is also the principal investigator. After each completed interview, each participant will receive $15.00 cash.

Data Storage to Protect Confidentiality

Your identity will be protected and under no circumstances be shared in the course of this research study or in any other publication. All information that is provided by you will be strictly confidential and all the information or data from you will be coded and securely stored by the principal investigator and used for professional purposes only.

How the Results Will Be Used:

In partial fulfillment of requirements for a Doctor of Nursing at the College of Nursing, University of Wisconsin-Milwaukee, Milwaukee, WI, the research study will be submitted. The results of this this research study will be published as a dissertation and may be used for education purposes in nursing publications or in professional presentations.

PART 2: Participant's Rights

1. I have read and discussed the research description with the principal researcher and have had the opportunity to ask questions about the procedures and purposes regarding this research study.

2. My participation in this research study is voluntary. I may withdraw or refuse to participate at any time without jeopardy to future medical care or other entitlements.

3. The principal researcher my withdraw me from the research at any time based on her professional discretion.

4. If new, significant information develops during the study and relates to my willingness to continue to participate, the principal investigator will provide that information to me.

5. Any information from the research that personally identifies me will not be voluntarily released or shared without my separate consent, except as required by law.

6. Any questions, comments or concerns I have about the of research or my rights as a participant in the research study, I can contact the researcher's primary number at: ___________________ or email: chronic.illness2020@gmail.com or researcher's faculty advisor, Kim Litwack, PhD, APNP, FAAN at 414-229-5554.

7. Comments or concerns I may have regarding the conduct of the research, I can reach the Institutional Review Board at 414-662-3544 or email them at irbinfo@uwm.edu

8. I should receive a copy of the Research Description and this Participant's Rights document.

9. Audio recording is part of this research and only the principal researcher and members of the research team will have access to the written and recorded information from me. Please check one:
   () I consent to be audio recorded
   () I do NOT consent to be audio recorded

My signature, or verbal consent if telephone or virtual interview will be done, means that I agree to participate in this study.
Participant's signature: _____________________________________ Date: ___/____/____
Name: (Please print): _______________________________________

Investigator's Verification of Explanation

I, _______________________ (Researcher), certify that I have carefully explained the nature and purpose of this research to _________________________________ (Participant's name). He has had the opportunity to discuss it with me in detail and I have answered all his questions where he has provided the affirmative agreement to participate in this research.
Investigator's signature: ___________________________________ Date: ___/_____/____

Appendix H. Second Manuscript from Chapters 2 and Chapter 5.

Critical Race Theory and Reflexivity to Inform Research and Action Against Racialization to Improve Black Men's Health

Racial health disparities continue to be a public health crisis despite decades of research and public health efforts to improve population health. Epidemiologic debates over theory and its implications for understanding population health have coincided with the growth of racial health disparities research over the past several decades. According to Mannor et al., (2022), no systematic analyses have characterized uses of theory in explanatory studies of racial health disparities or assessed how this literature has engaged structural approaches. Further assessment of racial health disparities is necessary to understand its impacts to inform public health action in providing assurance for people of color to be healthy. Since racial health disparities research is a social activity, explicit theorizing is required to challenge White dominant values that perpetuate within health care practice/systems, health education and health research to support health inequity (Mannor et al., 2022).

Background

Black Existentialism

Most research that is being conducted among Black Americans in the U.S. is through the lens of European existentialism. This lens is where the presupposition of individual self-determination and accessibility functions as an impediment, therefore, limiting potentially across racial contexts. What is needed for Black American individuals is a philosophical way of seeing, acknowledging, and exploring their experiences and meaning making (Vereen et al., 2017).

Black existentialism provides the philosophical grounding to explore the struggle to live within inequity, racialization, and historical oppression as experienced by Black Americans.

Black existentialism is concerned with the liberation of people who have historically not been viewed as human. Both European existentialism and Black existentialism have similarities in that they both value agency and liberation whereas the difference is evident in the belief that all individuals have equal access to systems that support agency and liberation. Black existentialism acknowledges the inequity of access for all while challenging the axiom that before agency there must be liberation, the precursor, and necessary foundation to accessing agency that has not been historically afforded to Black Americans.

Using the lens of Black existentialism as philosophy, with roots in advocacy, social justice, and radicalism, can increase understanding and the view of where inequity, marginalization, racialization is situated as Black Americans search to experience agency in the world. Black existentialism provides historical context of the racial traumas and current racialization suffered by Black populations in the U.S. from the dominant White culture (Vereen et al., 2017).

Furthermore, the pursuit of self-defined collective identity has been a historical theme for Black Americans. Pursuit of identity is due in part to a lived experience of hegemony and the colonization of Black people which further intersects with the denial of physical and psychological freedom. Black Americans exist in a world as a non-White person and as a Black person in relation to the White dominant society. Therefore, Black Americans often lack a consistent homogeneous environment due to their existence in a Black, White, and human world. As a result, the potential for confusion could emerge further creating fractures to self into different yet interdependent entities. Hence, the question that comes for Black American persons is their essence and the freedom to choose, which are the basic elements/constructs of existentialism and humanism that can be denied when living in an anti-Black world. Yet they can be challenged through a Black existentialist perspective and a critical lens that encapsulates these elements through the lens of the Critical Race Theory.

Critical Race Theory

Critical race theory (CRT) is a critical social theory or philosophy to identify where racism exists. Critical race theory is supported through tenets to further understand how racism has evolved and remains to benefit the dominant culture from a historical, societal, and contextual force within the U.S. To be true to the tenets which provides a guiding framework for usage, deep reflection and reflexivity is necessary before applying the theory to increase awareness and understanding of racism in the American society perpetuating consequences (See Table 1, Critical Race Theory Tenets and Descriptions).

Table 1. Critical Race Theory Tenets and Descriptions

Basic Tenets of Critical Race Theory	**Description of Tenets**
1. Racism is ordinary	Racism is difficult to address or cure because it is not acknowledged. Concept of color-blind or formal concepts of equality that remedies only the most blatant forms of discrimination.
2. Interest convergence or material determinism	Racism advances the interests of both white elites, materially, and working-class, psychologically, therefore large segments of society have little incentive to eradicate it.
3. Race is a social construct	Race and races are products of social relations and thought, where society frequently chooses to ignore these scientific truths and gives pseudo-permanent characteristics.
4. Differential racialization & its consequences	Dominant society racializes different minority groups at different times in response to changing needs, such as labor market or with stereotypes and images of various minority groups.
5. Intersectionality & anti-essentialism	No individual has a single, unitary identity.
6. Unique voice of color	Minority status brings with it a presumed competence to speak about race and racism to inform their white counterparts.

Adapted from Delgado & Stefancic (2017).

The first tenet of the CRT is that racism is ordinary, not aberrational but rather an everyday occurrence for persons of color in the U.S. The first feature of racism is that it is ordinary, difficult to address or cure because it is not acknowledged. Rather, the concept of color-bind is now used to demonstrate that everyone is equal, which only remedies blatant forms of discrimination (Delgado & Steffancic, 2017).

The second tenet or feature of CRT called interest convergence or material determinism, advances both working-class whites (mentally) and wealthy or elite whites (materially). There is little incentive to eradicate racism since it benefits large segments of U.S. society (Delgado & Steffancic, 2017).

The third tenet is that race is socially constructed and is the product of social relations and thought. Race is not inherent, fixed, or objective and does not correspond to any biological differences but is a category that society manipulates, invents, or retires from when it is convenient.

Differential racialization is the fourth tenet where the dominant society racializes different minority groups at different times in response to shifting needs such as a labor market. An example of this would be the need for Mexican or Japanese agricultural workers (Delgado & Steffancic, 2017, p. 10).

The fifth tenet is intersectionality, which was described earlier, and the sixth tenet concerns the unique voice of color, where different groups of color may be able to communicate to their white counterparts about their experiences and histories with oppression (Delgado & Steffancic, 2017, pg. 11). Being of minority status, in other words, presumes with it the competence to speak about race and racism (Delgado & Steffancic, 2017, p. 11).

Critical race theory was first developed in the late 1970s to ignite further social justice that continued to surround racial issues in the U.S. since post-civil rights efforts were declining. Derrick Bell is considered the father of this theory which originated in legal studies (Delgado & Stefancic, 2017). In 1991, Bell gave a sobering speech, “Racism is here to stay: Now What?” This angered many as he spoke the truth about racism. He stated, “That our society continues to have racism internalized and institutionalized to the point that it is essential and inherently a functioning component.” He further shared that the U.S. lives in a culture where racial discrimination has been a regulating force for stability and growth for other cultures to maximize from.

Bell further stated that there is an unavoidable truth in the U.S. society where there is a belief and determination for White dominance. Racism is manifested by the deeply entrenched determination where Whites build their self-worth by maintaining Blacks in a subordinate status (Bell, 1991). He ends his speech with some hope that activism can help and provide some triumph.

Civil rights activists continue with the fight for social justice. One truth that drives the use of the CRT is that racism exists. Intersectionality can further perpetuate marginalization for people of color, leading to worsening outcomes on many levels in the U.S. society. Although this one truth exists the experiences, beliefs, and perspectives of people of color regarding racism can be different.

Since its origination, the theory integrates transdisciplinary methodologies from the disciplines of education, sociology, cultural studies, ethnic studies, women’s studies, philosophy, political science, psychology, and most recently public health (Solorzano et al., 2000). CRT was implemented for the ongoing racial issues in the U.S. that have led to structural racism (Ford &

Airhihenbuwa, 2010a). These issues continue to inhibit social equities economically, legally, politically, emotionally, mentally, and physically. CRT is not like most theories but rather a dynamic philosophy to guide those who use its framework in their work.

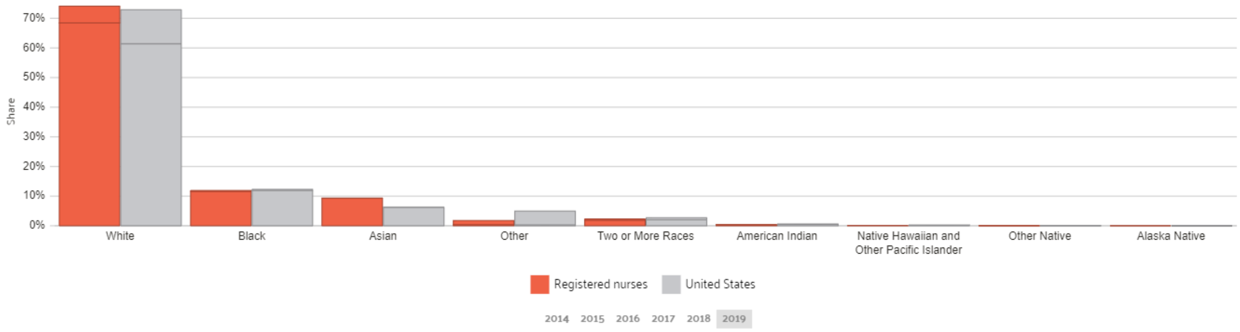
Kimberle Crenshaw, 2011, shared her sentiments regarding the CRT from her legal perspective as such. She felt that the CRT is not comprised of themes, theories, or practices but rather constituted by convergences and contestations on the ways racial power is articulated and understood in the post-civil rights era. She further suggests that shifting the frame of CRT to a dynamic rather than a static reference would be productive means to link CRT's past to the contemporary.

Ford and Airhihenbuwa (2010a) describe CRT as not a "theory" like some of the epidemiological or behavioral theories. Instead, it serves as an iterative methodology to guide investigators to remain attentive to equity during their practice, research, or scholarship. Scholars should be diligent to transform the hierarchies they identify through their research and deep reflection and reflexivity.

Reflexivity and Reflection

Reflection and reflexivity are necessary actions to utilize before applying critical race theory within the U.S.'s White dominate society and within the health care system. Racism needs to be addressed among health care providers in practice, education, and research in the. Since health care in the U.S. is dominated by White clinicians, with the largest being female nurses, the first step is considering their positionality of privilege (see Table 2. DATA USA: Registered Nurses, U.S. Census Bureau ACS PUMS 1 Year Estimate 2019).

Table 2. DATA USA: Registered Nurses, U.S. Census Bureau ACS PUMS 1 Year Estimate (2019).



Through deep reflection, reflexivity and the education and the scholarship works of Dr. Robin Diangelo, white, woman, and sociologist, health care providers, health care educational curriculums, scholars and researchers can recognize the very nature of a lifetime of White experiences in a racialized society and culture (Diangelo, 2018). The White experience is neither universal or objective yet the Western, U.S. culture has two key ideologies of individualism and objectivity. These two key ideologies make it very difficult for White people to explore the collective aspects of the white experience (Diangelo, 2018).

Modern racism cannot be understood if White people cannot or will not explore patterns of group behavior and their effect on individuals (DiAngelo, 2018). According to the American Nurses Association (ANA, 2020), the Code of Ethics for nurses obligates nurses to advocate and be allies against racism, injustice, and discrimination where the ANA has taken positions against discrimination, racism and health care disparities to advocate for human rights (ANA, 2020). Therefore, nurses must realize the increasing racial disparities in the health of Black Americans and how racism perpetuates racial disparities between Whites and people of color (DiAngelo, 2018). Next, racism and social determinants of health will be discussed in how they impact Black American health.

Racism as the Root of Social Determinants of Health

The social determinants of health framework identify five social factors that are linked to racial health disparities: 1) economic stability; 2) education; 3) social and community context; 4) health and health care; 5) neighborhood and built environment (Yearby, 2020). Although increased life expectancy and improved health outcomes have continued to rise, disparities in health among low socioeconomic (SE) groups or persons of color has not (Chen et al., 2014; Lewis et al., 2011; Gee & Ford, 2011; Ford & Airhihenbuwa, 2010).

As of 2018 in the U.S., racial health disparities are estimated and continues to cost $175 billion in lost life years and $135 the billion in excess health care costs and untapped productivity. Racial health disparities and its burden on society continues due to the failure to account for and address structural racism, the root cause of racialized disparities. Structural racism is defined as the macrolevel systems, institutions, social forces, ideologies, and processes that interact to further generate, reinforce, and perpetuate inequities among racial and ethnic groups (Powell, 2008). Segregation, income, employment opportunities, occupational risks, and exposures as well as neighborhood exposures of pollutants or violence are all examples of structural racism, especially among African Americans (Williams & Cooper, 2019; Gee & Ford, 2011; Ford & Airhihenbuwa, 2010b; Williams & Mohammad, 2009; Marmot & Wilkinson, 2011, Barr, 2014).

Health care, education, housing, public health, and employment are racially structured in the U.S. to advantage the majority while disadvantaging racial and ethnic minorities (Yearby 2020). Policy and law are tools used to create and sustain differential conditions by structuring them in a racialized discriminatory manner (Yearby, 2020). Therefore, acknowledging that racism exists and persists, the need for increased understanding of those living with the consequences of racism must be a priority to act against structural racism.Education and economic impacts on racial health disparities will be discussed.

Education and economic impacts on racial health disparities

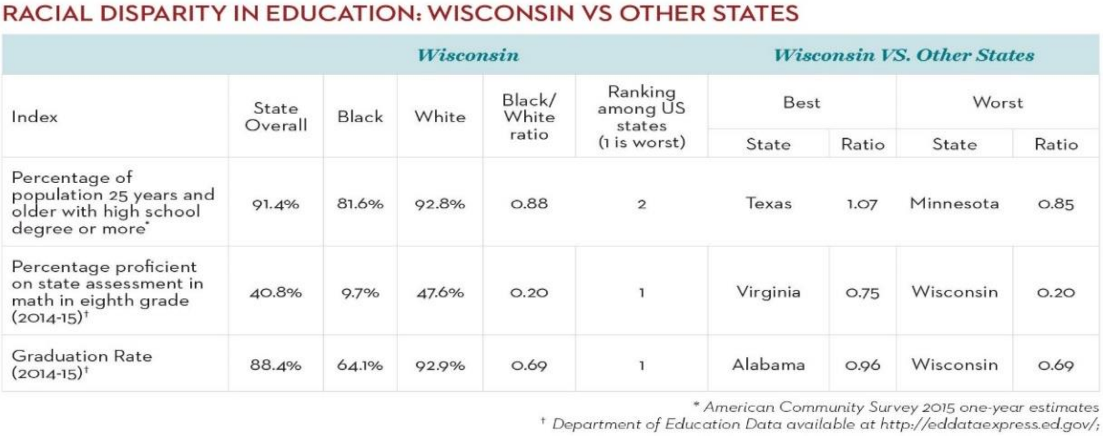
Living as a minority in the U.S. leads to lower educational attainment, employment opportunities, and income equity (Berkman et al., 2014). Black Americans are the poorest race/ethnic group in the U.S. (Iceland, 2013). According to the U.S. Census Bureau, in 2017, 21.2% of all Black Americans were below poverty compared to 10.7% of their White counterparts (Fontenot et al., 2018). Studies and statistical findings have supported that low education attainment, having disabilities, being a child in some areas of the U.S., and being a person of color contribute to low socioeconomic status (Nazroo & Williams, 2011; Iceland, 2013).

According to the 2017 U.S. Census Bureau, 24.9% of those without a high school diploma live below the poverty level compared to 12.7% with a high school diploma (Fontenot et al., 2018). The graduation rate of 64.1% and the eighth-grade math proficiency assessment of only 97% among Blacks or African Americans are both far less than their White counterparts.

More recent data from the U.S. Census Bureau (2017), the poverty level in Wisconsin was 10.5 % and below the U.S. poverty level of 12.8%, but its neighboring states had lower levels. Minnesota’s poverty level was 8.6%, Iowa’s at 9.7%. Illinois was higher than Wisconsin at 11.3% (Fontenot et al., 2018). The census report stated that poverty was the highest in large cities, which could contribute to the states of WI and IL, and their larger cities of Milwaukee and Chicago (Fontenot et al., 2018). The graduation rate of 64.1% and the eighth-grade math proficiency assessment of only 97% among Blacks or African Americans are both far less than their white counterparts.

More specifically in the state of Wisconsin, racial disparities in education and economic existence. The American Community Survey from 2015 demonstrates racial disparities among Black versus White education attainment, (See Table 3. Racial Disparity in Education: Wisconsin VS Other States).

Table 3. Racial Disparity in Education: Wisconsin VS Other States



RACIAL DISPARITY IN EDUCATION: WISCONSIN VS OTHER STATES

	Wisconsin					*Wisconsin VS. Other States*			
Index	State Overall	Black	White	Black/ White ratio	Ranking among US states (1 is worst)	Best		Worst	
						State	Ratio	State	Ratio
Percentage of population 25 years and older with high school degree or more[*]	91.4%	81.6%	92.8%	0.88	2	Texas	1.07	Minnesota	0.85
Percentage proficient on state assessment in math in eighth grade (2014-15)[†]	40.8%	9.7%	47.6%	0.20	1	Virginia	0.75	Wisconsin	0.20
Graduation Rate (2014-15)[†]	88.4%	64.1%	92.9%	0.69	1	Alabama	0.96	Wisconsin	0.69

[*] *American Community Survey 2015 one-year estimates*

[†] *Department of Education Data available at http://eddataexpress.ed.gov/;*

Social Stratification and Economic Impacts

Social stratification refers to a system that categorizes individuals into levels or ranks creating a hierarchy within its society (Moffit, 2015). Social stratification is based on four principles: 1) it is a trait of a whole society not just a reflection of one individual; 2) is universal but varies within each society; 3) persists over generations; and 4) involves not just inequality but beliefs that are rooted within the society's philosophy (Moffit, 2015; Iceland, 2013).

Social stratification across groups occurs when one social group finds methods to maximize their benefits by restricting others to resources or opportunities, such as the use an external identifiable characteristic of another group such as race, language, religion or social origin as a pretext for their exclusion (Iceland, 2013).

A similar concept, interest convergence, or material dominance, a tenet of CRT (Delgado & Stefancic, 2017). Interest convergence or material dominance occurs where racism advances the interests of both white elites (materially) and working-white class (psychically) which further perpetuates social and structural racism as large segments of society have little incentive to eradicate it (Delgado & Stefancic, 2017DiAngelo, 2018).

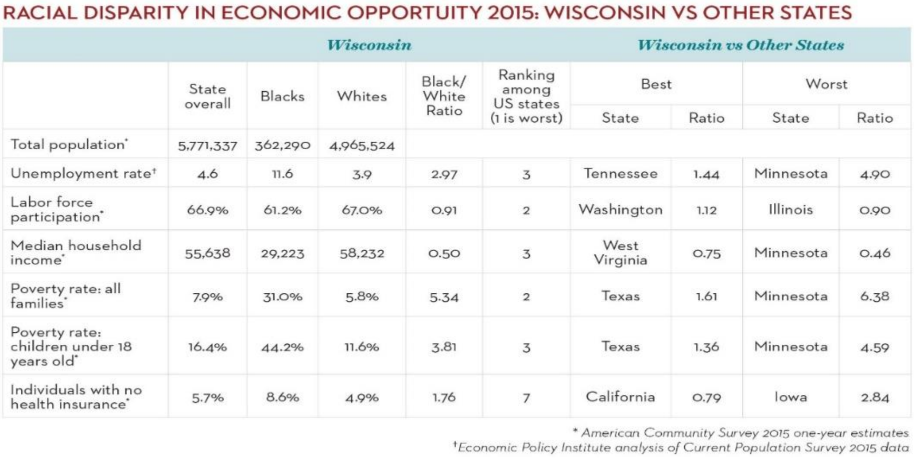
In 2010, Black Americans only comprised 13% of the U.S. population and have had to contend with more discrimination, including a severely constrained labor market throughout the nineteenth and into the twentieth century (Iceland, 2013). Since the civil rights movements, discrimination and racial segregation are not eliminated but are now found in the economic conditions that have an increasing role of determining Black disadvantage (DiAngelo, 2018). Economists estimate that a quarter of the Black-White wage gap is a result of prejudice, suggesting that racism continues to add to Black American economic disadvantage and the economic challenges faced by low-income Black Americans remains daunting (Iceland, 2013). Poverty in the U.S. has driven by social stratification where economic and social institutions generate inequality and poverty.

Racial or ethnic stratification impacts several minority groups fare worse than Whites on several social and economic indicators (Iceland, 2013). Minorities on average are more likely to have lower levels of education, wages, employment and are likely to have chronic health problems which are all characteristics of higher poverty rates (Iceland, 2013). Increased concentrated poverty in the 2000s contributed to the overall poverty in that decade, where the Midwest had the greatest impact, the hardest by continued industrial declines (Iceland, 2013). The impacts of low-income, racial stratification, and racial segregation led to racial health disparities among Black Americans compared to their White counterparts and will be discussed.

Evidence exists demonstrating how socioeconomic conditions, across the life course for Black Americans, further influence health status as early as pregnancy or early childhood were both set an adverse biological process in train (Barr, 2014). For example, low birth weight from a mother's circumstances, of the lifetime of the mother, is associated with high rates of diabetes, coronary heart disease, respiratory disease, and hypertension in adult life (Barr, 2014). Similarly, short stature, influenced by poor nutrition earlier in life, can be related to an increased risk of cardiovascular or respiratory mortality (Marmot & Wilkinson, 2011). The impact of socio-economic disadvantage on health can accumulate across the life span or "weathering" for the health of Black women in the U.S. (Marmot & Wilkinson, 2011).

The median household income in 2014 for Black Americans was $35, 398 compared to $53, 657 for all other races. There are greater racial disparities with socioeconomic status (SES) differences in the state of Wisconsin for Black Americans. According to the American Community Survey (2015), demonstrates how the unemployment rate, median household income, poverty rates of children and families, and those without health insurance are significantly higher (See Table 4. Racial Disparity in Economic Opportunity in 2015: Wisconsin vs. Other States).

Table 4. Racial Disparity in Economic Opportunity 2015: Wisconsin VS Other States)



RACIAL DISPARITY IN ECONOMIC OPPORTUITY 2015: WISCONSIN VS OTHER STATES

	Wisconsin					*Wisconsin vs Other States*			
	State overall	Blacks	Whites	Black/ White Ratio	Ranking among US states (1 is worst)	Best		Worst	
						State	Ratio	State	Ratio
Total population*	5,771,337	362,290	4,965,524						
Unemployment rate†	4.6	11.6	3.9	2.97	3	Tennessee	1.44	Minnesota	4.90
Labor force participation*	66.9%	61.2%	67.0%	0.91	2	Washington	1.12	Illinois	0.90
Median household income*	55,638	29,223	58,232	0.50	3	West Virginia	0.75	Minnesota	0.46
Poverty rate: all families*	7.9%	31.0%	5.8%	5.34	2	Texas	1.61	Minnesota	6.38
Poverty rate: children under 18 years old*	16.4%	44.2%	11.6%	3.81	3	Texas	1.36	Minnesota	4.59
Individuals with no health insurance*	5.7%	8.6%	4.9%	1.76	7	California	0.79	Iowa	2.84

** American Community Survey 2015 one-year estimates*
†Economic Policy Institute analysis of Current Population Survey 2015 data

Among those who are low-income, low birth weight, heart disease, diabetes, obesity, elevated blood lead levels are more prevalent in this population (Noonan et al., 2016). In addition to living in low-income, the onset of disease and disability occurs prematurely, as stated above, further perpetuating low SES. Research has shown that education attainment explains some poverty issues on an individual level, but more focus on how structural factors impact poverty needs to be considered (Iceland, 2013). Living with the social determinant low SES impacts overall health.

Low Socioeconomic Position on Health

Poverty is a critical issue in the U.S. with many short and long-term consequences. First, the hardship that accompanies poverty has adverse effects on individuals' psychological and physical well-being. Children raised in poor families are less healthy, less cognitively developed, have worse academic achievement, low emotional well-being, and eventually, as adults, die at younger ages (Iceland, 2013). Second, there are broad economic consequences from increased rates of poverty since economies thrive in societies with the vibrant middle class, and third, there are serious political and social consequences with elevated levels of poverty (Iceland, 2013). As low-income people often feel alienated from mainstream society, poverty provokes social disorder, crime and reduces public confidence in democratic institutions where individuals don't feel supported by the prevailing system (Iceland, 2013).

Social and Community Context Impacting Racial Health Disparities

Understanding and knowing the social position of a person within the hierarchy of a society predicts health outcomes for that person (Marmot & Wilkinson, 2011, pg. 6). Research exists to understand how the social environment impacts biology to cause disease by the response to external demands (Marmot & Wilkinson, 2011). According to the Center for Disease

Control and Prevention (2014), social determinants of health (SDoH) are social and economic conditions that impact health in communities influenced by the amount of power, money, and resources individuals have which are determined by policy choices. Social determinants affect health outcomes from supports as early child health development, amount of education, job sustainability, occupational exposures, food security, access to health services and the quality of these services, income, housing status, social supports, and discriminations (Center for Disease Control and Prevention, 2014).

Social inequalities or social stressors continue to exist in the U.S. but are now largely the result of differences in adult mortality. For example, during the COVID-19 pandemic, employment laws benefited Whites with unions for sick time but excluded racial minorities for union representation with no benefits of sick paid time off. The disparity of racial and minority health is one of the causes of racial disparities in COVID-19 infections and deaths as most were essential workers and did not have the advantage to stay home if they were sick compared to their White counterparts (Yearby, 2020).

Racism on the Social Impacts on Black Men's Health

African American men's repeated encounters with prejudice and racism manifests to "invisibility syndrome", which is defined as an inner struggle, feeling that one's talents, personality, abilities, and worth are not valued or recognized due to prejudice and racism. The invisibility syndrome further fosters inherent stress for African American men as it impacts the management of their identity (Wade & Rochlen, 2013). The repeated prejudice and racism that African American men face has shaped their masculinity.

To contextualize masculinity for African American men, in a White dominant culture, examining how racial minority groups define masculinity is necessary. Hegemonic masculinity, a sociological theory, argues that masculinity for nondominant groups (e.g., racial minorities) have taken forms that have been strongly influenced by their subjugation or marginalization within their respective societies. Therefore, considering the masculinity of the African American man needs to account for not only the White Western masculine norms but the racial oppression and its effects. Furthermore, African American men's masculinities are a dynamic product of negotiations between the minority and majority cultures, where contending with ongoing racial oppression continues to threaten their identity and masculinity (Rogers et al., 2015).

The impact of the historical trauma of slavery to the prevalent racialized U.S. society of current U.S. culture has shaped the masculinity of today's Black American man. Most young Black men acquire power by stylizing their bodies over space and time in such a way that their bodies reflect their uniqueness and provoke fear in others (Wade & Rochlen, 2013). Another name for these behaviors is "cool pose" that is a ritualized form of masculinity which entails scripts, behaviors, impression management, physical posturing, and carefully crafted performances that deliver a single critical message: strength, pride, and control that is particularly acute among low-income Black American men (Wade & Rochlen, 2013; Rogers et al., 2015). To be "bad" is good, not simply because it undermines the language of the dominant culture but also because it imposes a unique kind of order for young black men which promotes attention that makes others pull back with some trepidation. This young male style is a form of self-identification and resistance in a hostile culture and is also an example of machismo identity ready for violent encounters.

Black machismo, in a patriarchal society, is expected and exalted that solicits violence against women, other Black men, against White men while in prison together, or aggression toward police. The search for power usually results in a confrontation with the order imposing authorities, the police, and the criminal justice system (Sargent 2010; Wade & Rochlen, 2013). Research regarding policing and the current criminal justice system has increased consequences. According to Walsh (2021), police patrolled Black neighborhoods and arrested Black people disproportionately, prosecutors indicted, and juries found Black people guilty disproportionately; judges have given longer sentences to Black people, demonstrating that historically, crime data has never been objective in any meaningful sense and further weaponized to justify police brutality, racial profiling and increased policing of Black people (Walsh, 2021).

Mass Incarceration Impacts on Health of African American Men

Currently, the U.S. has the highest rate of incarceration in the world. No other country in the world imprisons so many of its racial or ethnic minorities. The U.S. prison system incarcerates a larger percentage of the Black population than South Africa did in the height of apartheid (Alexander, 2012). In Washington D.C., it is estimated that three out of four young black men in nearly all those in the lowest-income areas can expect to serve time in prison and these rates of incarceration in Black communities across America are like those found in the U.S. capitol (Alexander, 2012). The stark racial disparities cannot only be explained by rates of drug crimes since studies have shown that persons of color use and sell illegal drugs at a similar rate.

Mass incarceration among Black American men has a racial dimension in the U.S. Since the 1980s, mass incarceration of African American men in the U.S. is important to consider in how it provides context on both historical, past thirty years, and current social issues faced by Black American men (Alexander, 2012). The penal population exploded from around 300,000 to more than 2 million in the 1980s with the “war on drugs” campaign, with drug convictions accounting for most of the increase. African Americans are incarcerated 5.1 times greater in state prisons but the ratio in the following five states: 1) New Jersey; 2) Wisconsin; 3) Minnesota; 4)

Iowa, and 5) Vermont is even greater at ten to one. According to the U.S. Census Bureau from 2013, Wisconsin, had the second-highest rate of African American men imprisoned, for every White man, twelve African American men are incarcerated.

A literature review by Schnittker et al., (2011), investigated articles on previous research on the effects of incarceration on the health of African Americans on an individual and aggregate-level research. The risks of poor health reflect a transitive logic spanning post-incarceration and other well-established social risk factors such as unemployment, low income, and the unlikelihood of marriage which all impact health. Also, most inmates are first exposed to prison during young adulthood and many health differentials may not appear until midlife when condition rates and disparities across groups become more apparent (Schnittker et al., 2011),

Since the majority of those incarcerated are men, the stress on the family and communities can be even greater than on the prisoner. The strong social stigma of incarceration on families and communities can have similar impacts of similar illnesses. Once the prisoner is released, supporting his family is challenging with lower wages, unstable employment, discrimination, divorce and eventually contribute far less to their families and live away from them (Schnitter et al., 2011). The rate of recidivism, social isolation, increased use of substance and alcohol abuse, smoking, poor health, and lower quality of life exists for Black men during and post-incarceration (Mukku et al., 2012). Racialization and discrimination in the U.S. health care settings will be discussed.

Impacts of Racism on African American Health and Health Care

Experiences of and awareness of racism are central to the lives of ethnic minority people. In a U.S. study, eighty percent of African American respondents reported experiencing racial discrimination at some point in their lives. One in every eight African Americans, experience some form of racial harassment in the past year in the form of racial insults, repeated victimization, and a quarter of the minority respondents were fearful of racial insults (Marmot & Wilkinson, 2011). Studies have shown that Black American men experience racial harassment and discrimination more frequently than Black American women and further research suggests that the experience of racism may be qualitatively different for men and women of African descent (Wade & Rochlen, 2012; Wesley, 2015).

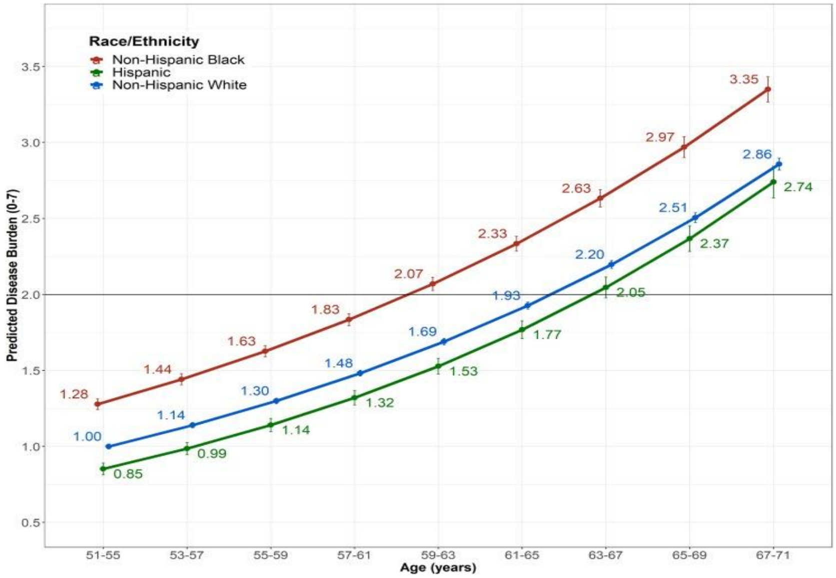
Intergenerational and historical racial trauma exposure persists among generations and lifetimes for Black Americans impacts their health negatively from deleterious effects through negative cognitive and emotional phenomenon. This exposure leads to psychopathology and morbidity as posited by McEwen's Allostatic Model (Marmot & Wilkinson, 2011; Juster et al., 2009; Barr, 2014). The Allostatic Model proposes that daily, stressful life events diminish coping mechanisms, genetic make-up through epigenetic events that damage physiological, immunological, and neuronal systems (Lu & Halfon, 2003; Saban et al., 2014; Barr, 2014).

Black Americans especially have shown that increased stress from racism predisposes them to earlier onsets of chronic conditions such as cardiac disease, obesity, diabetes, and depression (Barr, 2014). In 2015, Black Americans in the age range of 50-64 years of age, had significantly more chronic illnesses per person and a death rate of 31% higher than Caucasians in the same age group (Chen et al., 2014; Cunningham, et al., 2017).

Most middle-aged adults live with at least one chronic illness but persons of color and/or living in low-income have more than one chronic condition by midlife (Quinones et al., 2019). A longitudinal study examined the racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults. The results are provided in Table 5.

African Americans start with an earlier burden of chronic disease and develop multimorbidity at an earlier age than Caucasians (Quinones et al., 2019).

Table 5. Non-Hispanic Black, non-Hispanic White, and Hispanic trajectories of chronic disease accumulation over time, HRS 1998–2014 (Quinones et al., 2019).



Earlier onsets of multiple morbidity and premature deaths are the highest among middle-aged Black Americans in the U.S. and most deaths are occurring from chronic conditions with HIV being the leading cause of deaths then cerebral vascular disease, diabetes, cancer, and heart disease to follow, which all occur at higher rates among low-income populations (Cunningham et al., 2017).

Racism & Discrimination in Health Care

Structural racism exists regarding access to health care and within health care. The obstacle of no transportation, health insurance, and access to health care limits a person's ability to preventative services until emergencies arise. Although the rate of those uninsured declined from the Affordable Care Act (ACA) for those 18-64 years of age, there remains a difference in those uninsured among African Americans and Latinos compared to Caucasians (Noonan et al., 2016). Besides, not all states implemented Medicaid expansion under the ACA, which largely impacts those who are low-income and are minorities (Medicaid.gov, 2016). According to the Kaiser Foundation, 40% of eligible Black Americans reside in states who have rejected the Medicaid expansion and are twice as likely to be uninsured than Caucasians and Latinos (Artiga et al., 2016).

Lastly, a study by Han et al., (2015), was done with states who did not expand Medicaid. In this study, low-income adults between the ages of 18-64 who are more likely to be Black American, are less likely to have a routine care provider, and less likely to use preventative services. Also, Black Americans were more likely to report not being able to see a doctor because of cost, even though across age groups, Blacks and Whites equally reported having a health care provider (Cunningham et al., 2017). Studies regarding the physical encounters between Black Americans and health care providers (HCP) have been conducted that surround biases, discrimination, and racism which have been identified by both Black American patients and health care providers (HCP) (Beach et al., 2011; Hausman et al., 2011; Martin et al., 2013; Adebayo et al., 2019; Williams & Cooper, 2019).

Communication barriers between health care providers and their patients surround discrimination, implicit or subconscious bias. According to Abramson et al., (2015), a quantitative study was conducted to examine the perceived discrimination in U.S. healthcare by minorities. The findings indicated racial minorities were more likely to report perceptions of discrimination, which was statistically significant among Black Americans and Native Americans (Abramson et al., 2015). Poor self-reported health and communication difficulties during clinical encounters were associated with increased perceptions of discrimination among all groups (Abramson et al., 2015).

The Council on Ethical and Judicial Affairs of the American Medical Association did a comprehensive on the issue of racial bias among physicians in 1990. From this report, recent studies have found when Black Americans gain access to health care, they are less likely than Caucasians to receive certain surgeries, treatments, or therapies (Barr, 2014, pg. 204). A study by Hoffman et al., (2016), found that health care providers, based on false personal beliefs of biological differences between Black Americans and Whites, routinely undertreat Black Americans who report pain.

Another qualitative study used focus groups of Black Americans, separated by gender, to discuss their perceptions of communication with health care providers. Perceived discrimination, especially among Black American women, was described when sharing symptoms or their concerns were discredited by health care providers (Cuevas et al., 2016). African Americans also had fears that contributed to issues regarding their chronic diseases and where time is considered a social determinant of health rooted in racism.

Racism Impacts of Time

According to Kwate, (2017), time for African Americans is an SDoH in that it perpetuates racial health inequities. Meaning, that African Americans in the U.S. experience time lost across many domains throughout the life course further positioning them at risk for disproportionate morbidity and mortality. Racialized time indirectly harms health by disrupting or denying access to societal resources that are structurally limiting to African Americans such as power, money, freedom, prestige, knowledge, and social networks. Racialized time harms the health of African Americans directly when it produces stress and exacerbates conditions of racialized subordination. Specifically, Kwate (2017) examined three racialized areas for African Americans 1) spending too much time to meet basic needs, 2) having less time spent on them than is required, and 3) lost years of good quality of life. experiences and the impact of SDoH on the African American U.S. culture. Racial segregation will be presented and how this impacts Black American health.

Racism Impacts on Neighborhood and Built Environment

Segregation

Racial segregation is defined as the physical separation of races where housing options for African Americans is limited to the least desirable residential areas (Moffit, 2015). Segregation emerged in the 19th and 20th centuries to ensure that Caucasians were protected from the residential proximity of African Americans, which was imposed by legislation, supported by major economic institutions and enshrined by the housing policies of the federal government and enforced by the judicial system and legitimized by an ideology of White supremacy that was advocated by the church and other cultural institutions (Marmot & Wilkinson, 2011).

Considerable demographic and socio-economic diversity persist among the major racial/ethnic groups in the U.S. and is further complicated by the geographical and segregation of ethnic and racial minority groups, a prominent theme in the U.S. (Marmot & Wilkinson, 2011). In the first decades of the twentieth century, class and racial segregation began increasing in the Northern cities as the Black population began to increase with the Great Migration North of Southern Black people (Iceland, 2013). The 1960s and 1970s brought the term “ghetto” as poverty rates increased in these cities resulting from past governmental policies, ethnic and racial discrimination, residential segregation, economic changes, and employment relocations (Iceland, 2013). The low-income areas that were developing in the cities were less desirable to more prosperous persons which started their relocation to the suburbs according to Moffitt and Urban Institute (Iceland, 2013).

Segregation is a key determinant of racial differences in socio-economic mobility and further creates health-damaging conditions in social and physical environments (Marmot & Wilkinson, 2011). Elevated levels of segregation have distinctive ecological environments that are higher crime, less quality housing, less green space or access to healthy foods further impacting African American health (Marmot & Wilkinson, 2011; Williams & Cooper, 2019; Barr, 2014; Iceland, 2013; DiAngelo, 2018). Racial segregation has further contributed to social stratification in the U.S. (Moffit, 2015).

Locations of poverty vary by region in the U.S. and were more concentrated in central cities in the 1970s and 1980s but have now decreased (Iceland, 2013). In more recent years, suburban and pockets of rural poverty have become more widespread where social problems such as crime, welfare dependency, drug use, and substandard educational outcomes are more common in areas of extreme poverty (Iceland, 2013; Barr, 2011). The lack of economic opportunities and prominent levels of ethnic, racial and class segregation exist in high poverty areas too (Iceland, 2013).

Characteristics of low-income populations are described as marginalized, or socially excluded. Living in low-income further indicates the degree to which persons suffer from multiple forms of social deprivation, including consumption of goods, employment, social interaction, and political engagement (Iceland, 2013). Also, the longer a person remains in poverty the less likely that one will escape it (Iceland, 2013).

Living in low SES increases risks for food insecurity, transportation, and health care access, which all are SDoH and essential components to health (Marmot & Wilkinson, 2011). Deprivation of food nutrition, adequate housing, safety, sense of well-being, mental health, access to health care, and transportation are resources that are needed in low-income communities for a better quality of life (Shaw et al., 2011). Within low-income neighborhoods, food deserts exist without easy access to supermarkets with fresh produce and other healthy foods (Barr, 2014). Several studies have shown in low-income, African American neighborhoods, there are the less fresh and lower quality of food in the supermarkets and contrast, have numerous alcohol outlets where obesity and diabetes prevalence are high within these neighborhoods (Noonan et al., 2016; Gaskin et al., 2014). Lastly, how the impact of environmental racism impacts Black Americans will be discussed.

Impacts of Environmental Racism

Environment racism is the unequal access to basic environmental resources and a clean environment based on race. Persons of color are disproportionately victimized by environmental hazards and far more likely to live in geographical areas with heavy pollution and hazardous waste (Patnaik et al., 2020). Black Americans who live in low-income communities are disproportionately affected by air pollution with more than one million Black Americans living within a half-mile of natural gas facilities and over a million-face cancer risks due to Environmental Protective Agency's (EPA's) concern of unsafe levels of unclear air (Crane, 2019; EPA). Exposure to poor air quality can also cause numerous respiratory health issues like asthma (Crane, 2019; US EPA, 2022). More than 6.7 million Black Americans live in ninety-one counties with oil refineries. In total Black Americans are 75% more likely than their White counterparts to live in "fence-line" communities which consist of commercial facilities that produce noise, odor, traffic, or emissions that directly affect the population.

In addition, low-income, minority populations are more likely to live near industrial facilities and are therefore at a higher risk for chemical spills and toxic leaks resulting from tropical storms. For example, sixty percent of Black Americans in Baltimore live a mile or less of a Toxic Release Industry while seventy percent live two to four miles of one (Patnaik et al., 2020)

Conclusion

Conceptualizing racism from the historical, social, and current context through a critical race approach is needed to further understand how to advocate and provide a voice to Black men and their health. Reflection and reflexivity behavioral practice and self-realization of one's social position in a White dominated society is required with the utilization of CRT. Only through the first step of reflection and reflexivity can a person gain self-realization to proceed with the next action of recognizing how racism affects an individual's health, longevity, and quality of life. The action of providing a voice to those of color should include more research through community participative engagement.

Community engagement has been gaining traction in research, practice, and policy over the past several decades. Community engagement is the process of collaborative work with and through groups of people, or aggregate, with similar situations or interests, within geographic proximity to address issues affecting the well-being of the aggregate. The overall goals of community engagement are to enlist new allies and resources, build trust, create better communication, and improve health outcomes with successful projects to support ongoing collaborations (McCloskey et al., 2011).

Community engagement is rooted with the recognition that behaviors, lifestyles, and incidence of illness are shaped by physical and social environments or socioecological views. Socioecological views also consider that health inequities and inequalities have larger roots in socioeconomic conditions. Since poor health outcomes are more determined by social issues, in this case of structural racism, engaging community partners with their perspectives, and understandings of community life can best approach the health concerns with a collaborative project. When racial health inequities stem from unjust, socioeconomic policy, health improvement must include the concerns of the communities who are impacted, who are diverse or marginalized population (McCloskey et al., 2011). Community participative research using the socioecological model will be discussed next.

Multiple factors affect health from the individual, to relationships, communities, organizations, policies, and the environment. Researchers, health professionals, community leaders consider these concepts as they intersect and impact each other using the socioecological model. The socioecological model helps to identify at different levels the individual, the interpersonal level, the community, society, policy, and environment that contribute to poor or negative health outcomes. Approaches are developed to increase health promotion, and disease prevention among the levels with the overall goal of integrating interventions to change the physical and social environments, rather than modifying only at the individual level (Mcloskey et al, 2011). The study did address the participants understanding and perspectives of their chronic health conditions, but the demographic questions, and semi-structured interview provided opportunities for the men to share how interpersonal, community, their society, some policy and their environment impacted their overall health, with racism as the root of everything. The last recommendation would be further research using the socioecological model and CRT with individual interviews and then focus groups or community participative research for their perspectives, understanding and methods to improve their well-being and overall quality of life holistically.

References

American Nurses Association (2020), ANA's membership assembly adopts resolution on racial justice for communities of color. Retrieved from https://www.nursingworld.org/news/news-releases/2020/ana-calls-for-racial-justice-for-communities-of-color/#:~:text=The%20Code%20of%20Ethics%20for%20Nurses%20with%20Interpretive,health%20care%20disparities%20and%20advocating%20for%20human%20rights.

American Nurses Association (2015). View the code of ethics for nursing. Retrieved from

https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

Abramson, C.M., Hashemi, M., Sanchez-Jankowski, M. (2015). Perceived discrimination in U.S. healthcare: Charting the effects of key social characteristics within and across racial groups. *Preventative Medicine Reports, 2*, 615-621. doi.org/10.1016/j.pmedr.2015.07.006.

Adebayo, C.T., Walker, K., Hawkins, M., Olukotun, O., Shaw, L., Parcell, E.S., Dressel, A., Luft, H., & Mkandawire-Valhmu, L. (2019). Race and blackness: A themat. ic review of communication challenges confronting the Black community within the U.S. health care system. *Journal of Transcultural Nursing*, 1-9, doi: 10. 1177/104365961988911

Affordable Care Act (2010). Retrieved from https://www.healthcare.gov/glossary/affordable-care-act/

Alexander, M. (2012). *The new Jim Crow, mass incarceration in the age of colorblindness.* The New Press.

American Nurses Association (2020), ANA's membership assembly adopts resolution on racial justice for communities of color. Retrieved from https://www.nursingworld.org/news/news-releases/2020/ana-calls-for-racial-justice-for-communities-of-color/#:~:text=The%20Code%20of%20Ethics%20for%20Nurses%20with%20Interpretive,health%20care%20disparities%20and%20advocating%20for%20human%20rights

Artiga, S., Damico, A., & Garfield, R. (2015). The impact of the coverage for adults in states not expanding Medicaid by race and ethnicity, The Kaiser Commission on Medicaid and the uninsured. Retrieved from kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-for-adults-in-the-states-not-expanding-medicaid-by-race-and-ethnicity/

Barr, D.A. (2014). *Health Disparities in the United States: Social Class, Race, Ethnicity Health* (2nd ed.). Johns Hopkins University Press.

Beach, M.C., Saha, S., Korthuis, P.T., Sharp, V., Cohn, J., Wilson, I.B., Eggly, S., Cooper, L.A., Roter, D., Sankar, A. & Moore, R. (2011). Patient-provider communication differs for Black compared to White HIV-infected Patients. *AIDS and Behavior, 15*(4), 805-811. doi: 10.1007/s10461-009-9664-5

Bell, D. (1991). Racism is here to stay: Now what? *Howard Law Journal 35*, 79-93. Retrieved from file:///C:/Users/klone/Downloads/35HowardLJ79%20(1).pdf

Centers for Disease and Control and Prevention (2019). Social determinants of health. Retrieved from https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#what-are-social-determinants

Centers for Medicaid and Medicare (2016). Advanced care planning. Retrieved on December 17, 2019 from www.medicare.gov/coverage/advance-care-planning

Chen, R.V. (2014). Racial/ethnic health disparities in chronic disease interventions and services across socio-ecological model (Doctoral dissertation). Available from ProQuest Dissertations and Theses databases (UMI No. 3631720).

Crane, M. (2019). Low-income, black neighborhoods still hit hard by air pollution. Retrieved from https://cfaes.osu.edu/news/articles/low-income-black-neighborhoods-still-hit-hard-by-air-pollution

Crenshaw, K.W. (2011). Twenty years of critical race theory: Looking back to move forward. *Connecticut Law Review 43*(5). Retrieved from http://shain003.grads.digitalodu.com/blog/wp-content/uploads/2014/09/Twenty-Years-of-Critical-Race-Theory-Looking-Back-to-Move-Forward.pdf

Cuevas, A.G., Dawson, B.A., & Williams, D.R. (2016). Race and skin color in Latino Health: A systematic review. *American Journal of Public Health, 106*(12); 2131-2136. doi: 10.2105/AJPH.2016.303452

Cunningham, T.J., Croft, J.B., Liu, Y., Lu, H., Eke, P.I., & Giles, W.H. (2017). Vital signs: Racial disparities in age-specific mortality among blacks or African Americans-United States, 1999-2015. *Morbidity and Mortality Weekly Report, 66*(17), 444-456. http://dx.doi.org/10.15585/mmwr.mm6618a11

Delgado, R., & Stefancic, J. (2017). *Critical race theory: An introduction* (3rd ed.). University Press.

DiAngelo, R. (2018). *White fragility: Why it's so hard for white people to talk about racism.* Beacon Press Books.

Fontemont, K., Semega, J., Kollar, M. (2018). Income and poverty in the United States: 2017, Retrieved from https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-263.pdf

Ford, C. & Airhihenbuwa, C. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health, 100*(S1); S30-S35. doi: 10.2105/AJPH.2009.171058

Gaskin, D.J., Thorpe Jr., R.J., McGinty, E.E., Bower, K., Rohde, C., Hunter, J.H., LaVeist, T.A., & Dubay, L. (2014). Disparities in diabetes: The nexus of race, poverty, and Place. *American Journal of Public Health, 104*(11); 2147-2155. doi: 10.2105/AJPH.2013.301420

Gee, G.C. & Ford, C. (2011). Structural racism and health inequities. *Du Bois Review,8*(1); 115-132. doi: 10.1017/S1742058X11000130

Han, X., Nguyen, B.T., Drope, J., & Jemal, A. (2015). Health-related outcomes among the poor: Medicaid expansion vs. non-expansion states. *Public Library of Science ONE, 10*(12); doi: 10.1371/journal.prone.0144429

Hausmann, L.R., Hannon, M.J., Kresevic, D.M., Hanusa, B.H., Kwoh, C.K., & Ibrahim, S.A. (2011). Impact of perceived discrimination in health care on patient-provider Communication. *Medical Care, 49*(7); 626-633. doi: 10.1097/MLR.0b013e318215d93c

Hoffman, K.M., Trawalter, S., Axt, J.R., & Oliver, M.N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America, 113*(16), 4296-4301. doi: 10.1073/pnas.1516047113

Juster, R.P. McEwen, B.S. & Lupien, S.J. (2010). Allostatic biomarkers of chronic stress and and impact on health and cognition, *Neuroscience Behavior Review, 35*(1), 2-16. doi: 10.1016/j.neubiorev.2009.10.002

Lu, M.C. & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A life course Perspective. *Maternal Child Health Journal, 7*(1), 13-30. doi: 10.1023/a:1022537516969

Kwate, N.O.A. (2017). The race against time: Lived time, time loss, and Black health Opportunity. *Du Bois Review, 14*(2), 497-514, doi: 10.1017/S1742058X17000145

Mannor, K.M., & Malcoe, L.H., (2022). Uses of theory in racial health disparities research: A scoping review and application of public health critical race praxis, *Annuals of Epidemiology 66*, 56-64. https://doi.org/10.1016/j.annepidem.2021.11.007

Marmot, M. (2011). Introduction. In M. Marmot & R.G. Wilkinson (Eds), *Social determinants of health* (2nd ed.; p. 3). Oxford University Press

Martin, K.D., Roter, D.L., Beach, M.C., Carson, K.A., & Cooper, L.A. (2013). Physician Communication behaviors and trust among Black and White patients with hypertension. *Medical Care, 51*(2), 151-157, doi:10. 1097/MLR.0b013e31827632a2

Moffit, K. (2015). Social stratification: Definition, theories & examples. Retrieved from https://study.com/academy/lesson/social-stratification-definition-theories-examples.html

Moffit, K. (2015). Social stratification: Definition, theories & examples. Retrieved from https://study.com/academy/lesson/social-stratification-definition-theories-examples.html

Mukku, V.K., Benson, T.J., Alam, F., Richie, W.F., & Bailey, R.K. (2012). Overview of substance abuse disorders and incarceration among African American males, *Frontiers in Psychology, 3*(98); 1-5. doi: 10.3389/f.psyt.2012.00098

Noonan, A.S., Valsco-Mondragon, H.E. & Wagner, F.A. (2016). Improving the health of African Americans in the USA: An overdue opportunity for social justice. *Public Health Reviews, 37*(12); 2-20. doi: 10.1186/s40985-016-0025-4

Patnaik, A., Son, J., Feng, A., Ade, C. (2020). Racial Disparities and Climate Change. Retrieved from https://psci.princeton.edu/tips/2020/8/15/racial-disparities-and-climate-change

Quinones, A.R., Botoseneanu, A., Markwardt, S., Nagel, C.L., Newsom, J.T., Dorr, D.A., Allore, H.G. (2019). Racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults. *PLOS One, 14*(6), 1-13. doi.org/10.1371/journal.pone/0218462.

Rogers, B.K., Sperry, H.A. & Levant, R.F. (2015). Masculinities among African American men: An intersectional perspective. *Psychology of Men & Masculinity, 16*(4), 416-425. doi.org/10.1037/a0039082

Saban, K.L., Matthews, H.L., DeVon, H.A., & Janusek, L.W. (2014). Epigenetics and social context: implications for disparity in cardiovascular disease. *Aging & Disease, 5*(5); 346-355. http://dx.doi.org/10.14336/AD.2014.0500346

Sargent, R. (2010). Representing prison rape: Race, masculinity, and incarceration in Donald Goines's white man's justice, black man grief. *Multi-Ethnic Literature of the U.S., 35*(3), 131-155.

Schnitter, J., Massoglia, M., & Uggen, C. (2011). Incarceration and the health of the African American community, *Du Bois Review, 8*(1), 133-141. doi: 10.1017/S1742058X11000026

Shaw, M., Dorling, D. & Smith, G.D. (2011). In M. Marmot & R.G. Wilkinson (Eds), *Social* *determinants of health* (2nd ed.; pp. 196-223). Oxford University Press.

Solorzano, D., Ceja, M. & Yosso, T. (2000). Critical Race Theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *Journal of Negro Education*, *69*(1/2), 60-73.

US EPA (2022). Heat Islands and Equity. Retrieved from https://www.epa.gov/heatislands/heat-islands-and-equity

Vereen, L.G., Wines, L.A., Lemberger-Truelove, T., Hannon, M.D., Howard, N., Burt, I. (2017). Black existentialism: Extending the discourse on meaning and existence. *Journal of Humanist Counseling, 56*, 72-84. doi: 10.1002/johc.12045

Wade, J.C. & Rochlen, A.B. (2012). Introduction: Masculinity, identity and the health and well-being of African American men. *Psychology of Men & Masculinity, 14*(1), 1-6. doi: 10/1037/a0029612

Walsh, C. (2021) Experts say approach must be comprehensive as roots are embedded in culture, Retrieved from https://news.harvard.edu/gazette/story/2021/02/solving-racial-disparities-in-policing/

Wesley, L. (2015). The intersection of race and gender: Teaching reformed gender ideologies to Black males in the context of hegemonic masculinity. *Journal of Black Sexuality and Relationships*, *1*(4), 63-84. doi.org/10.1353/bsr.2015.0010

Williams, D.R. & Cooper, L.A. (2019). Reducing racial inequalities in health: Using what we already know to take action. *International Journal of Environmental Research and Public Health, 16*(606), 1-26. doi:10.3390/ijerph16040606

Appendix I. Chapter 5 Manuscript

Critical Race Pedagogy Praxis: Transformation in Nursing Practice, Research Practice, Research & Policy

Racism is a public health crisis further impacting all aspects of a person's mental, physical, and spiritual life (American Nurses Association, 2021). With the advent of the Black Lives Matter movement following the death of George Floyd, the contestation against systemic oppression based on racial identity has been growing. There is also growing recognition, in White mainstream America of how racism is embedded in long-standing policy and how it affects individuals and communities (Bailey et al., 2021). Racism is thus produced and reproduced through policies and regulations sanctioned and implemented at various government levels and further embedded in economic systems, becoming societal and cultural norms (Bailey et al., 2017; Rothstein, 2017).

For African Americans, racism has been made manifest throughout the legacy of enslavement, to the present day, impacting population and individual health within three interrelated domains: police violence and mass incarceration, redlining and racialized residential segregation, and unequal and inequitable healthcare (Bailey et al., 2021). Ongoing exposure to racism has negative consequences on a person's health that can start as early as in utero. Racism occurs through discriminatory interactions in the form of both macro and micro aggressions. Resulting in premature morbidity and mortality for African Americans compared to their White counterparts due to structural racism and has been a concern for decades (Bailey et al., 2021).

To give a specific example, African American men are dying in middle age at higher rates, even though the life expectancy gap is narrowing between White and African Americans.

African American men thus experience more premature morbidity and mortality than any other race/ethnicity or gender in the U.S. (Quinones et al., 2019; Thorpe and Whitfield, 2018), see Table 1.

Racism, which occurs within the healthcare system and affects health outcomes is not in alignment with the Nursing Code of Ethics. Nurse must serve as allies and advocates and speak up against discrimination, racism, and injustice. In January 2021, leading nursing organizations in the U.S. launched a *National Commission to Address Racism in Nursing*, also referred as, *The Commission* (American Nurses Association, 2021). There are three purposes of the Commission: to examine the issue of racism in nursing; to describe its impact on health care systems, populations, patients, and nurses; and ensure that the nursing profession confronts and addresses systemic racism (American Nurses Association, 2021). *The Commission*, or coalition, is long overdue as racism has already, for decades, permeated all aspects of society, including the healthcare system.

Within *The Commission*, nursing leaders address how nurses must exemplify ethical principles foundational to nursing practice while promoting health equity for communities of color by advocating for access and resources as a form of racial and social justice (American Nurses Association, 2021). Nurses need to remain accountable in calling out racism and disrupting racist policies and racist acts in healthcare. Racist polices are rooted in White supremacy and must be replaced with ethical policies that advance racial equity and lead to the elimination of racial disparities.

In this manuscript, the authors will demonstrate how a paradigm shift in nursing curricula and nursing pedagogy is needed to cultivate a praxis pedagogy through the lens of critical race theory (CRT) and cultural safety. Using the tenets or concepts within CRT and cultural safety, nurse educators, clinicians, and scientists can disrupt racism within nursing practice, curricula, research, policy and across the profession. The concept of praxis pedagogy, according to Freire (2005), involves reflection followed by action directed at the structures that need to be transformed. In this case, through reflection and reflexivity, using the tenets of CRT, a nurse can contribute to transformation throughout all aspects of the profession. The tenets or concepts of CRT are tools which can be used to increase understanding and transform attitudes in areas in which structural racism impacts the healthcare system. Critical race scholars posit that the concepts of race and racism in higher education are rarely a focal point as they relate to the analysis of academic success and achievement for students of color, for example (Allen, 2017; Closson, 2010). CRT reminds educators to take the time to understand how racism works, identify it within oneself, recognize it for what it is, and to take action to do something about it. By responding to the call for social justice activism, nurses can use their influence to fight for equity for marginalized groups (Allen, 2017).

The authors will also discuss how self-reflection/reflexivity and action enables nurses to transform the profession to become more race conscientious and to continue to cultivate action that addresses race and racism. The charge for social justice activism using CRT in higher education and health care systems will be addressed, specifically the health of African American men, who suffer disproportionately from the effects of racism and whose unique healthcare needs in this regard, are often overlooked than any other gender or race/ethnicity (Allen, 2017, Quinones, 2019). The use of critical race theory (CRT) and cultural safety within the nursing profession to address racism in healthcare and the disparate outcomes that specifically affect African American men will also be discussed[1.] The utility of critical race praxis pedagogy alongside a cultural safety framework is centered on the first author's work experiences in this manuscript. The first author has progressed in her journey through research, community nurse practice and as a nurse educator, identifying racialized barriers to low income, middle-aged African American men with three or more chronic health conditions and how this impacts their quality of life and symptom management.

Racism as a Structural Determinant of Health

W.E.B. Dubois, in 1906, pointed out that racial disparities in mortality rates, among African Americans were caused by social conditions and not genetics (Yearby, 2020). Not until 2010, did the federal government formally acknowledge that social conditions, specifically social determinants of health (SDoH), accounted for racial health disparities. Five key factors within the SDoH framework contribute to racial health disparities: social and community aspects; education; health and health care, economic stability; and built environment and neighborhood. Racial health disparities, as of 2018, are estimated to cost the U.S. $175 billion in lost life years and $135 billion in untapped productivity and health care costs which persist from the failure to address and account for structural racism, the root cause of racial health disparities (Yearby, 2020).

Structural racism affects health care, education, employment, housing, and public health, benefitting the majority across these sectors while disadvantaging ethnic or racial minorities (Yearby, 2020). Structural racism produces differential outcomes for Whites and racial or ethnic minorities within the five key areas of SDoH, noted earlier, leading to racial health disparities. For example, employment laws that date back to the Jim Crow era, 1864-1964, left ethnic and racial minorities without paid sick leave or union representation. This issue persists today as many racial or ethnic minorities, many of whom are employed as essential workers, are unable to stay home when they are sick (Yearby & Mohapatra, 2020). Another example of racial health disparities is the higher rates of infection and deaths due to COVID-19, where in Milwaukee, WI, African American death rates are higher than their percentage of their population (Powell, 2020). One population which is significantly impacted by structural racism are African American men's.

The health of African American men is central to the first author's work and we speak to the needs of African American men here as a particularly underserved population impacted by racism. For African American men, the experiences of racism are historically rooted in stereotypes often advanced by the media, which portrays them as dangerous and more likely to commit crime (Yearly, 2020). Structural racism impacts Black American men's health not only the individual level (intrapersonal level) but at an interpersonal level. African American Men report that they don't receive information regarding the seriousness of their complex health conditions when living with diabetes, hypertension, and kidney disease and mental illness. Except when told they could have heart attacks or a stroke from unmanaged hypertension, most of the advice or education from healthcare providers has been related to short-term planning or interventions, such as taking medications, implementing healthier eating and increased activity (Walker, in press). Meanwhile not addressing the stress of managing comorbid conditions and other stressors resulting from structural racism like living with lower income, inadequate housing, and community violence is not included in discussions with health care providers (Brown & Hargrove, 2018; Thorpe et al, 2015).

African American men experience structural racism that impacts where they live, their socioeconomic status and opportunities for education and employment (Thorp et al., 2020). Black American men may experience interpersonal racism in for the form of microaggressions, for example, being followed around at department stores (Borresen, 2020). African American men may also experience systemic racism in the form of over policing and hypervigilance, which can endanger their lives as has been more recently broadcast and become more hyper visible with the advent of social media regarding the cases of George Floyd and Ahmaud Arbery.

Community disinvestment and resultant disadvantage exists within low-income areas and includes not only physical risks but deficiencies in healthy food choices due to food deserts and increased availability of convenient stores and liquor and tobacco retailers further exposing African Americans to risk factors for chronic disease. (Thorpe et al., 2020). In addition, Black American men are at greater for unstable employment, inadequate housing and report increased use of alcohol, tobacco, or illicit drugs for coping stress (Hudson et al, 2018). These patterns of coping have many different effects across the life span of African American men ranging from their ability to attain education, limited employment opportunities to mass racialized incarceration, and, poor health outcomes. (Thorpe at al., 2020)

Critical Race Theory

Critical race theory was first developed in the late 1970s to further a social justice agenda in relation to the racial issues in the U.S. post-civil rights. Derrick Bell is considered the father of critical race theory which originated in legal studies (Krieger, 2012). In 1991, Bell gave a sobering speech, “Racism is here to stay: Now What?” This angered many as he spoke specifically about racism (Bell, 1991) stating, “Our society continues to have racism internalized and institutionalized to the point that it is essential and inherently a functioning component.” He concluded that racial discrimination is a regulating force which furthers advantage in terms of stability and growth for the dominant White culture in the U.S. (Bell, 1991).

Bell also noted the unavoidable truth in U.S. society which is the belief and determination for White dominance (Bell, 1991). Racism manifests because of the deeply entrenched determination to maintain their privilege of the White population by keeping Black Indigenous People of Color in a subordinate status (Bell, 1991). Bell ended his speech with the hope that activism could be the force to move US society towards the urgently needed societal transformation and equity.

Critical race theory is a critical social theory that not only examines how racism but, sexism, and classism persists (Delgado & Stefancic, 2017). The theory is based on tenets or concepts, see Figure 1, that guides its application. CRT calls us to be more race conscience and recognizing that policies, within every sphere of life, and acts have systematically led to the oppression and suffering of non-White populations.

Contentions and barriers of CRT

Contentions regarding the use of CRT have existed since the theory was started but more recently with the rise of the Black Lives Matter movement since the murder of George Floyd in the spring of 2020 (Silverstein, 2021). Critical race theory became highly politicized after an article published by Rufo, a conservative activist writer in July 2020, who alleged that city employees in Seattle were in a “Whites only training, inducting them into the cult of critical race theory.” Rufo’s article was widely shared online, referencing a new method of voluntary courses in response to the murder of Floyd, even though Seattle’s City Office of Civil Rights had been conducting racial bias sessions for a decade prior. Rufo called CRT “cult programing” leading White Americans to believe they were being held responsible for all racism and calling for a ban on all CRT training sponsored by the federal government. The administration of President Donald Trump at the time, instructed federal agencies to stop all racial sensitivity training that involved discussions of CRT. Since then, President Biden has revoked the order (Suddath, 2021).

Within the education arenas, Ray, and Gibbons (2021) address the most recent contentions in the U.S. regarding the teaching of racism and CRT. The authors point out that opponents of CRT fear that the theory admonishes all White people for being oppressors while classifying all Black and Brown peoples as hopelessly oppressed victims, leading to school boards and state legislatures banning the teaching of content suggestive of racism in classrooms (Ray & Gibbons, 2021). The authors state that the narratives about CRT are gross exaggerations of the theoretical framework and make the argument that CRT does not attribute racism to White people as individuals or even groups but that rather racism is argued as being embedded social institutions, such as criminal justice system, education system, labor, the housing market and finally the healthcare system leading to differential outcomes on account of racial identity (Ray & Gibbons, 2021).

Higher education still approaches the use of CRT with apprehension due to the perspective that CRT takes on racism. The idea of racism being fundamental to U.S. society is unsettling to many (Hiraldo, 2010). Other critics claim that CRT only centers race and does not consider other identities like gender or class; however, intersectionality or anti-essentialism is a tenet of CRT where CRT scholars work to address these social identities within their analysis (Hiraldo, 2010).

There are indeed many barriers to discussions of racism using CRT tools for nurse educators. Challenging hegemonic beliefs requires significant work on the part of the educator. There must be intentionality and the creation of a safe space and a “brave space”, for students to explore racial issues (Smith, 2020). Leonardo and Porter (2010) have concluded that for marginalized and oppressed minorities no safe space for racial discussions exists. Mainstream race dialogue in education, or in any space, is arguably already unsafe and hostile for persons of color, whose perspectives and experiences are consistently minimized (Leonardo & Porter, 2010). A brave space, coined by Arao and Clemens (2013), encourages individuals, particularly those identifying as White, to consider new ideas or perspectives that may be uncomfortable or challenge their preconceived beliefs and values. A brave space further invites critical dialogue about how one's behaviors, intentional or not, may misalign with pure intentions for social justice professionally and personally on account of White privilege (French, 2019). When exploring topics that center on individual, cultural and national identities, instructors, or facilitators/leaders need to anticipate, welcome, and prepare for conflict in a brave space (Smith, 2020).

Critical Race Theory Application in Nursing

Sixty-nine and a half percent of nursing faculty identify as white compared to the 80.8 % of white registered nurses in the U.S. (Demographics and Statistics in the U.S.-Nursing faculty, 2019). Although there is more racial diversity among nursing faculty than the nursing workforce, all nurses have a role and responsibility to address social injustice resulting from structural racism. Through critical race praxis pedagogy, nurses can engage in a more emancipatory approach after gaining an understanding of how racism impacts marginalized groups, specifically Black Men (Beard & Wrenentha, 2016; Wesp et al., 2018).

According to the American Nurses Association, the nursing profession remains a White female profession nurse although shifts to diversifying the profession are occurring slowly, (See Table 2) (DATA USA: Registered nurses, 2019). A profession that is predominately White needs to explore its own racialized views, in the case of nursing, focusing on curricula, practice, research and theory, to critically examine how White privilege and White supremacy perpetuates racism within the U.S. health care system as well as within the nursing profession (Wesp et al., 2018; DATA USA: Registered nurses, 2019). The factors leading to lack of diversity also need to be explored and acknowledged as institutional racism and resultant barriers also pay an important role.

In 2013, the first author, a White, middle-aged woman, started teaching full time nursing at a Baccalaureate level using critical theory as her philosophical guide to help empower nursing students in their third semester course that focused on chronic illness in the community. Critical race theory allowed students to gain more confidence through open communication with the instructor and allowed for the creation of forums that permitted safe and brave discussions and enabled respectful but open perspectives of students. The students' communication, nursing skills and autonomy increased, and they often shared that they felt more comfortable and respected in this learning environment, because they had the ability to safely learn from mistakes.

CRT and Reflexivity in the Nursing Profession

Reflexivity, or reflection on positionality, requires a person to consider their relationship to privilege and power in prior, during and after they engage in identity-related work, including work related to race (Davis & Linder, 2017; Freire, 2005). Another descriptor for reflexivity is "reflection in action", where scholars or educators consider their positionality in the research process, engaging with participants and students respectively. Reflection in action requires ongoing awareness of the subtle ways that power influences relationships between people and attempts to mitigate these power differentials (Davis & Linder, 2017; Freire, 2005). Lastly, reflection in action is the process through which scholars engage in thoughtful and intentional reflecting of previous experiences related to research and teaching to consider ways they can improve future scholarship ensuring it does not mirror the racism and discriminatory tendencies within broader society (Davis & Linder, 2017).

Dr. Robin DiAngelo (2018), a renowned sociologist, speaks of how deep self-reflection and reflexivity along with further education informed by antiracist scholars, can help us understand how White experiences exist in a racialized society and culture. The White experience is neither universal or objective yet, U.S. society has two key ideologies, individualism, and objectivity. These two key ideologies make it difficult for White people to explore the collective aspects of the White experience (DiAngelo, 2018).

Modern racism cannot be understood if White people cannot or will not explore patterns of group behavior and their effect on individuals (DiAngelo, 2018). White nurse researchers, educators, academicians, and clinicians also need to set aside their ideologies of individualism and objectivity and grapple with the notion and reality that racism is embedded within U.S. society. DiAngelo's (2018) concept of White humility, which is part of her theory of white fragility, not only enables us to explore but to transform the consequences of racism (DiAngelo, 2018; Ramaswamy & Kelly 2015). Cultural safety is another framework, alongside critical race theory, which can inform nurses' antiracist work.

Cultural Safety

The need to include cultural safety within the practice of the first author was vital to consider on this journey toward antiracist praxis and health equity. The concept of cultural safety is different than cultural competence in that cultural safety focuses on the notion of power differentials within society and the requirement for health care professionals to reflect on interpersonal power differences, their own and the patients, and how these power differentials inform quality care for patients in the margins of society (Curtis et al., 2019). The practice of culturally safe care by the healthcare provider is also different from cultural competence because the focus here is the culture of the clinician or the clinical environment rather than the culture of the client (Erickson C. & Erickson, L., 2017). Dr. Ramsden and Māori nurses in the 1990's first proposed cultural safety in New Zealand defining it: "a focus for the delivery of quality care through changes in thinking about power and patients' rights" (Curtis, et al., 2019).

Cultural safety as a framework, involves acknowledging the barriers to effective provider and client interactions, informed by power imbalances within the health care encounter. Healthcare providers can establish better care and optimize health outcomes by increasing their awareness of difference, considering power relationships, decolonizing, implementing reflective practice and creating space where patients can determine whether a clinical encounter is safe. Self-reflection is a key element to cultural safety and requires health care providers to question their own biases, assumptions, attitudes, prejudices, and stereotypes that contribute to poor quality healthcare for patients (DeAngelo, 2018; Curtis, et al., 2019).

Most scholars are clear that the concept of cultural safety aligns with critical theory which encourages healthcare providers to examine sources of repression. Sources of repression include structurally embedded variables such as class, power, and social domination. Addressing these realities can lead to equity, social justice, and respect for those who are marginalized (Curtis et al., 2019).

Discussion and Recommendations

Further research is needed to reduce the pathogenic effects of racism (Williams et al., 2019). Urgent work on how to improve quality of life, decrease suffering and improve health outcomes needs to occur. Williams and colleagues (2019) argue that larger multilevel and comprehensive intervention strategies addressing racial disparities would be more effective than single interventions. It is however important to note that racism can only be addressed after nurses and allied health professionals have addressed their own personal and professional views, values and beliefs regarding structural racism and its negative impacts. A cultural safety framework along with the tools of CRT can be used to further explore one's beliefs, practices, and actions both personally and professionally (DiAngelo, 2018, Curtis et al., 2019; Smith, 2020).

Nurses, as healthcare leaders in the U.S., must ascribe to more critical self-reflection and move toward a critical race consciousness. Individual work must be done so that nurses can contribute to eliminating health disparities through practice, policy, and education. Nursing curricula needs to include course work that focuses on "safe and brave spaces" for deep, thoughtful discussions regarding racism where faculty and students are prepared for difficult responses from students (Smith, 2020).

Topics of race and racism are often under-examined in K-12 and in college settings, consequently leading students, and faculty to a limited understanding of the racial history or polices that shape institutions in the U.S. and ultimately people's lives (Smith 2020). Nursing needs the support of administration, faculty, peers, and outside support systems to apply antiracist praxis throughout nursing curricula, research, practice, and policy and to dismantle structural racism to promote social justice. CRT should be considered an essential tool for studying and transforming pedagogy to meet the goals of *The Commission* on racism. As Derrick Bell (1992) suggested, we need an Afro Atlantic Awakening to rekindle the soul and remind us that despite utopia, our collective struggle is in and of itself a hope anew.

References

Allen, M.E. (2017). The relevance of critical race theory: Impact of students of color, Urban

Education Research and Policy Annals, 4(2), 1-8. https://journals.charlotte.edu/urbaned/article/view/575

American Nurses Association (2021). Retrieved from https://www.nursingworld.org/news/news-releases/2021/leading-nursing-organizations-launch-the-national-commission-to-address-racism-in-nursing/

Arao, B. & Clemens, K. (2013). From safe spaces to brave spaces. A new way to frame dialogue around diversity and social justice issues, *The Art of Effective Facilitation*, 135-150. Stylus Publishing, LLC. Retrieved from https://www.gvsu.edu/cms4/asset/843249C9-B1E5-BD47-A25EDBC68363B726/from-safe-spaces-to-brave-spaces.pdf

Bailey, Z.D., Krieger, N., Agénor, M., Graves, J., Linos, N., Bassett, M.T. (2017). Structural racism and health inequities in the USA: Evidence and interventions, *Lancet, 389* 1453-63. doi: httpss://doi.org/10.1016/SO14036(17)30569- X

Bailey, Z.D., Feldman, J.M, Bassett, M.T. (2021). How structural racism works-Racist policies as a root cause of U.S. health disparities, *New England Journal of Medicine, 384*(8); 768-773. Retrieved from https://www.nejm.org/doi/pdf/10.1056/NEJMms2025396?articleTools=true

Bell, D. (1991). Racism is here to stay: Now what? *Howard Law Journal* 199; 35: 79-93. file:///C:/Users/klone/Downloads/35HowardLJ79.pdf

Bell, D. (1992). *Faces at the bottom of the well: The permanence of racism.* New York: Basic Books.

Beard, K. & Wrenentha, J. (2016). Does race still matter in nursing? The narratives of African American nursing faculty members, *Nursing Outlook; 64*; 583-596. doi.org/10.1016/j.outlook.2016.06.005

Borresen, K. (2020). Thirteen microaggressions Black people deal with all the time. Retrieved from https://www.huffpost.com/entry/microaggressions-black-people-deal-with_l_5ee8ffa9c5b6fe2600260ec8

Brown, T.H. & Hargrove, T.W. (2018). Psychosocial mechanisms underlying older Black Men's health, *Journal of Gerontology, Series B, Psychological Sciences Social Sciences, 73*(2), 188-197. doi:10.1093/geronb/gbx091

Closson, R.B. (2010). Critical race theory and adult education. *Adult Education Quarterly, 60*(3), 261-283.

Curtis, E., Jones, R., Tipene-Leach, D., Loring, B., Paine, S.J., Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition; 18 (174). https://doi.org/10/1186/s12939-019-1082-3

DATA USA: Registered Nurses (2019). Most common race or ethnicity of registered nurses, Census Bureau ACS PUMS 1 year estimate. Retrieved from https://datausa.io/profile/soc/registered-nurses

Davis, S. & Linder, C. (2017). Problematizing Whiteness: A woman of color and a white woman discuss race and research, *Journal of Dialogue Studies, 4,* 49-68. http://www.dialoguestudies.org/wp-content/uploads/2017/02/Journal-of-Dialogue-Studies-Vol-4-Shametrice-Davis-and-Chris-Linder-Problematizing-Whiteness-A-Woman-of-Color-and-a-White-Woman-Discuss-Race-and-Research.pdf

Demographics and Statistics in the U.S. Nursing Faculty (2019). Retrieved from https://www.zippia.com/nursing-faculty-jobs/demographics/

DiAngelo, R. (2018). *White fragility: Why it's so hard for white people to talk about* *racism.* Boston, MA: Beacon Press Books.

Erickson, C. & Erickson, L. (2017). Inequities in health care: Lessons from New Zealand: A qualitative interview study about the cultural safety theory. Retrieved from https://www.diva-portal.org/smash/get/diva2:1083289/FULLTEXT01.pdf

Freire, P. (2005). Pedagogy of the Oppressed, 30th ed., Continuum, NY.

French, K. (2019). The paradox of teaching for social justice: Interest convergence in early career educators. Urban Education, 1-26. Retrieved from https://www.uvm.edu/~vtconn/v31/Hiraldo.pdf

Hudson, D.L., Eaton, J., Banks, A., Sewall, W., Neighbors, H. (2018). American Journal of Men's Health, 12(1); 126-137. doi: 10.1177/1557988316654864

Krieger, L. (2012). Methods for the scientific study of discrimination and health: An Ecosocial Approach, *American Journal of Public Health, 105*(5); 936-945. doi: 10.2105/AJPH.2011.300544.

Leonardo, A. & Porter, R. K. (2010). Pedagogy of fear: Toward a Fanonian theory of 'safety' in race dialogue, *Race Ethnicity and Education, 13*(2), 139-157.

Powell, T. (2020). Milwaukee's COVID-19 spread highlights the disparities between White and Black. Retrieved from https://www.theguardian.com/world/2020/apr/14/milwaukees-covid-19-spread-highlights-the-disparities-between-white-and-black

Quinones, A.R., Botoseneanu, A., Markwardt, S., Nagel, C., Newsom, J., Dorr… Allore, H. (2019). Racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults, *PLoS One, 14*(6); 1-13. doi.org/10.1371/journal.pone/0218462.

Ramaswany, M. & Kelly, P.J. (2015). Institutional racism as a critical social determinant of health, Public Health Nursing 32(4); 285-286. doi: 10.1111/phn.12212

Ray, R. & Gibbons, A (2021). Appendix: Legislative and administrative actions against CRT. https://www.brookings.edu/blog/fixgov/2021/07/02/why-are-states-banning-critical-race-theory/

Rothstein R. (2017). *The color of law: a forgotten history of how our government segregated America.* New York: Liveright Publishing.

Silverstein, J. (2021). The global impact of George Floyd: How Black Lives Matter protests shaped movements around the world. https://www.cbsnews.com/news/george-floyd-black-lives-matter-impact/

Smith, A. (2020). Critical race theory: Disruption in teacher education pedagogy, *Journal of Culture and Values in Education 3*(1), 52-71. doi:10.46403/jcve.03.01.4

Suddath, C. (2021). How critical race theory became a political target, Bloomberg Equality. https://www.bloomberg.com/news/articles/2021-10-02/how-critical-race-theory-became-a-political-target-quicktake

Thorpe, R.J., Cobb, R., King, K., Bruce, M.A., Archibald, P., Jones, H.P., Norris, K.C., Whitfield, K.E., Hudson, D. (2020). The association between depressive symptoms and accumulation of stress among Black Men in the health and retirement study, Innovation in Aging, 4(5), 1-9. doi:10.1093/geroni/igaa047

Thorpe, R.J., Duru, O.K., & Hill, C.V. (2015). Advancing racial/ethnic minority men's health using a life course approach, *Ethnicity & Disease*, *25*(3); 241-244.

Thorpe, R.J. & Whitfield, K.E. (2018). Psychosocial Influences of African Americans Men's Health, *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 73*(2), 185-187. doi:10.1093/geronb/gbx125

Walker, K.A. (in press). *Black American men's Resiliency and Persistence to Grow Old* "Unpublished Dissertation," Universityof Wisconsin, Milwaukee.

Wesp, L.M., Scheer, V., Ruiz, A. Walker, K., Weitzel, J., Shaw, L. …Mkandawire-Valhmu, L. (2018). An emancipatory approach to cultural competency: The application of critical race, post-colonial, and intersectionality theories, Advanced Nursing Science, 41(4); 316-326. doi:10.1097/ANS.0000000000000230.

Williams, D.R. & Cooper, L.A. (2019). Reducing racial inequalities in health: Using what we already know to take action, *International Journal of Environmental Research in Public Health;16*(606);1-26. doi.org/10.3390/ijerph16040606.

Yearby, R. (2020). Symposium article: Structural racism and health disparities: Reconfiguring the social determinants of health to include root cause, *Journal of Law, Medicine and Ethics 48*(518); 1-16. Retrieved from file:///C:/Users/klone/Downloads/SYMPOSIUM%20ARTICLE_%20Structural%20Racism%20and%20Health%20Dispari%20(1).PDF

Yearby, R. & Mohapatra, S. (2020). Structural Racism, and the COVID-19 Pandemic, *Journal of Law & the Biosciences*, 1-20. doi: 10.1093/jlb/lsaa036