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a thesis submitted to the Faculty of Emory College of Arts and Sciences
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Abstract

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Greater awareness of the influence of socioeconomic, racial, and cultural factors on the health behaviors and beliefs of diverse US subpopulations may allow more personalized treatment plans and intervention programs for minorities. Unfortunately, research has yet to identify the health behaviors and beliefs of diverse US subpopulations through such a perspective. Most studies on the health practices of the African-American community mainly examined the health behaviors and folk beliefs of lower-class African-American women; very few studies have independently observed the health behaviors and attitudes of African-American women in higher social clases. Research has ignored the intraethnic variation among African-Americans created by age and social class through a homogenous classification of US blacks in the health literature. This study corrects this critical omission by providing information on the health practices of African-American women who have achieved higher socioeconomic status from a college education. African-American women between the ages of 20-80, who are members of a predominatly African-American sorority and residents of the Metro-Atlanta area, were contacted for recruitment in this study. I utilized a two-part methodology; I collected 106 survey responses and conducted three focus groups to ascertain information on participant demographics, health behaviors, experiences of racial discrimination, physician preferences, satisfaction with care, and trust in the healthcare system. Study results have provided deeper insight into the health attitudes, beliefs, and behaviors of college-educated African-American women, including self-treatment; delayed seeking of professional care; and the importance of balancing folk and biomedical care, and researching treatment options. Age did not appear to impact the health behaviors of study participants, indicating the cultural transmission of health behaviors and attitudes, especially mistrust in the healthcare system and utilization of home remedies. While college-educated African-American women may experience greater access to biomedical care, participants aged 20-59 reported that the high cost of health care still prevented them from seeking treatment when needed. This suggests gaps in the health care of study participants: college-educated African-American women may not receive the preventative care they need between the ages of 20-59 due to financial barriers to care.

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Chapter 1: Introduction

Efforts have been made to better understand the health behaviors and folk beliefs of African-Americans (Bailey 1988; Barnett et al. 2003; Barzargan et al. 2005; Bogart 2001; Boyd et al. 2000; Brown and Segal 1996; Heurtin-Roberts 2002; Hufford 1997; Pachter 1994; Schoenberg 1997; Snow 1993). However, such research has ignored the intraethnic variation inherent within this population. Most studies on this community only examined the health practices and attitudes of low-income African-Americans, who predominantly had a high school education or less (Bailey 1988; Barnett et al. 2003; Barzargan et al. 2005; Bogart 2001; Brown and Segal 1996; Heurtin-Roberts 2002; Schoenberg 1997; Snow 1993). Missing from the literature is information on the health behaviors and beliefs of African-Americans who have achieved higher socioeconomic status (SES) by obtaining a college education. This study will fill this gap through outlining the health attitudes, beliefs, and behaviors of college-educated African-American women. Results will highlight intraethnic variation in these health practices and offer greater insight into the impact of age, racism, culture, and social class on the health behaviors and attitudes of this population. These factors will be discussed to better recognize how they limit access to mainstream health care for this study population. Factors that have increased reliance on biomedical care, such as physician preferences, will be identified to provide a complete summary of the health behaviors of this population. Until these behaviors and beliefs are understood, healthcare providers cannot make informed decisions about the health care of African-American women.

About This Project

This research is especially relevant to the author. As a young child, I witnessed first-hand the use of folk medicine to treat hypertension among African-Americans, as described in the literature (Bailey 1988; Heurtin-Roberts 2002; Shoenberg 1997). I was raised by my father's mother, who was diagnosed with high blood pressure before I was born. Over the years, I never heard her discuss doctor's appointments nor saw her take any prescribed medication to treat her hypertension. I do, however, remember her talking about the folk remedies that she would use, which included vinegar, lemon juice, and Epsom salt. It was not until she was hospitalized for a heart attack when I was thirteen years old that I learned she had stopped taking her prescribed medication years before. I never got the chance to ask her why she stopped taking it, but remained curious to understand why some African-American women use folk treatments more than they utilize biomedical health care. I was also curious to discover if my grandmother's social class was the reason for her health behaviors. I wondered if she would still have treated herself differently or sought more care from a physician had she been in a higher social class.

I was also impacted by the numerous conversations I had with my fellow African-American female classmates and sorority sisters on healthy lifestyles. Despite the immense knowledge available about the benefits of eating healthy, avoiding "soul food", exercising regularly, and visiting a physician regularly, most of my classmates still religiously follow the health behaviors of their grandmothers and mothers and voice an unwillingness to change. This was surprising because I speculated a middle class background and greater access to care would prompt college-educated African-American women to engage in healthy behaviors more frequently than their counterparts with a high school education or less. It seemed odd that they would not use their higher socioeconomic position and access to biomedical knowledge to alter their lifestyles to ensure longer, healthier lives. These responses were even more surprising to me because I do not share them. I have made conscious efforts to follow public health recommendations, despite the actions of my mother and grandmothers. I recognized cultural learning has had a strong effect on the health behaviors of my counterparts. These sentiments were on the forefront of my mind when writing my proposal for this project. They drove me to desire a better understanding of the cultural health practices of African-American women that have had an impact on the health outcomes and disparities faced by this group.

Research Objectives

The primary goal of this research is to describe the health behaviors and attitudes of college-educated African-American women to determine the effects of culture, race, and social class on health perceptions. I wondered if middle-class African-American women still followed the old remedies passed down for generations to cure ailments; if there was still reluctance to seek care from a physician; if these women ate “soul food” more often than healthier food options; if poor communication with health care providers was responsible for noncompliance with medication and mistrust of physicians; or if “folk” practices had been abandoned in favor of more mainstream behaviors. To determine these outcomes, study results will be compared to the health literature on lower-class African-Americans. Results will shed light on the impact of higher SES on reducing health disparities. Despite past conversations, it is still my prediction that African-American women with higher incomes and educational levels will report better access to medical care, greater satisfaction with care, and greater reliance on biomedical care than African-American women with less education.

I also examine differences in the health behaviors and perceptions of college-educated African-American women across generations. I posit younger generations should have more numerous and more positive health care experiences and should thus report a greater reliance on biomedical care rather than folk traditions. I also hypothesize younger generations will be more likely to seek care from a physician when ill, and more likely to follow physician recommendations for treatment. In addition, I posit greater access to care will cause younger generations to report greater satisfaction with care, greater choice in healthcare provider, and greater participation during healthcare visits. These hypotheses are based on the historical exclusion of older African-Americans from health care, which resulted in the circulation of folk health beliefs and behaviors among older African-Americans (Barnett et al. 2003). Subsequently, I hypothesize older generations will be most likely to adhere to cultural health practices, exhibit distrust in their physician, recall experiences of discrimination while seeking health care, and report less satisfaction with care.

I investigate the racial/ethnic and gender preferences for physicians of this study population. Although some research in this area has been inconclusive, it is valuable to examine if racial concordance—when a patient and physician belong to the same racial/ethnic group—in physician-patient visits can erase some of the stigma against seeking health care and create greater reliance on biomedical care. As physician preferences can be impacted by experiences of racial discrimination, this will similarly be examined.

This research is interesting and valuable because the literature on the health care of African-Americans largely depicts the African-American community as a uniform group—excluding the impact of education, socioeconomic status, regional background, and age on their health behaviors and beliefs. Because health disparities are such a huge burden on the African-

American community and the US economy, it would seem more research would address the underlying factors of these disparities and design more interactions to decrease their impact. These realities have driven me to use this research to expand the understanding of the cultural health practices of college-educated African-American women and the barriers to care that this population continues to face.

This project identifies the widely-held cultural health beliefs of college-educated African-American women that govern reliance on biomedical and alternative care. A greater understanding of these health behaviors may be important in implementing strategies to improve health outcomes for culturally diverse populations, such as African-American communities (Brown 1996). It is my sincere hope the deeper understanding of the cultural health practices of college-educated African-American women provided by this study can help enhance health care for African-American women.

Health Behaviors and Beliefs

There are numerous factors that can impact the health care of an individual, including age, access to biomedical care, cultural heritage, satisfaction with care, perceived discrimination, provider attitude, religious beliefs, and race/ethnicity (Barnett 2003 et al.; Barzargan et al. 2005; LaVeist 2005; Pachter 1994). While all of these factors may have an equally important impact on the health of an individual, few disciplines have examined cultural beliefs about medical care. Anthropology is a discipline that has described the beliefs and behaviors of multiple subpopulations in the United States, including African-Americans. As defined by medical anthropologist Harwood, *health beliefs* and *health behavior* include:

> Techniques for health maintenance, standards for recognizing and evaluating symptoms, estimates of the seriousness of various conditions and of one's susceptibility to them, familiarity with biomedical disease categories, information about therapeutic resources (both medication and personnel) and how to obtain them, ways of interacting with health professionals (how to give a history, describe the problem, request specific services, and so on), and adherence to therapeutic regimens (Harwood 1988:6).

LaVeist (2005) offers a more concise definition: health behaviors are the set of actions that either prevent illness or make it more likely. Because these behaviors greatly impact the health of an individual, an understanding of the health behaviors across diverse subpopulations in the US is imperative[1].

Key to understanding the health practices and perceptions of diverse subpopulations is an understanding of culture. This position is supported by Sobo and Loustaunau who state, "In attempting to understand and analyze health and illness in any society, individual behaviors, interactions, and social structures must be placed within a cultural context. A **culture** is, put briefly, all the shared, learned knowledge that people in a society hold" (1995:9-10). Culture influences all domains of daily life: economics, religion, rituals, gender, modes of subsistence, etc. More importantly to this research, it impacts the ways individuals interpret and perceive health and illness, and influences their choices in providing and seeking care (Sobo and Loustaunau 1995:10). It can be argued that culture is one of the single largest influences on health behaviors and beliefs. However, mainstream health care in the US has frequently ignored the health behaviors of culturally diverse subpopulations in the US. As argued by Sobo and Loustaunau,

> The United States encompasses a great variety of ideas, philosophies, and practices within a core system for delivery of health care to a diverse population. This core system is based upon a biomedical model that generally has not

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[1] In order to avoid repetition, this thesis will use the terms *health behavior*/*health practices*, and *health beliefs*/*health attitudes*/*health perceptions* interchangeably.

> supported cultural awareness and sensitivity in health care delivery, recovery, or rehabilitation. It has also given little recognition to alternative healing systems and beliefs that exist side by side with biomedicine and that are often used instead of or in conjunction with mainstream care (1995:5).

Without fully understanding the impact of culture on health behaviors and attitudes, adequate health care cannot be provided.

Anthropological research has documented several ways in which culture can impact health behaviors; the work of Pachter (1994) and Kleinman et al. (1978) are particularly relevant. Through examining differences in the health beliefs of patients and physicians, Pachter determined culture leads to differences in perceptions, attitudes, knowledge, communicative styles, and approaches toward health-related issues. He further explained that individuals sharing common beliefs, ideas, experiences, knowledge, attitudes, and behaviors constitute a *cultural group*. There are several reasons for differences in health behaviors and attitudes across cultural groups. Differences arise due to varying personal experiences, family attitudes, and group beliefs, which interact to provide an underlying structure for decision making during illness (Pachter 1994). Thus, health behaviors are not just influenced by culture itself, they are also influenced by how culture shapes interactions with family members and other in-group members.

Although conducted over 30 years ago, the work of Kleinman et al. is still relevant because healthcare providers have still not adopted their recommendations. Kleinman et al. recognized that all individuals utilize “popular”/“folk” medicine—self-treatment, advice from relatives, self-help groups, religious practitioners, heterodox healers, etc.—more frequently than biomedical care. These researchers did not recommend that the healthcare sector expand to increase management of illnesses, but called for further understanding of the nature and efficacy of popular treatments and health behaviors. They describe all individuals undergo an "illness process" that begins with,

> Personal awareness of a change in body feeling and continues with the labeling of the sufferer by family or by self as 'ill.' Personal and family action is undertaken to bring about recovery, advice is sought from members of the extended family or the community, and professional and 'marginal' practitioners are consulted. This sequence may or may not include registration within the legitimized health system (1978:251).

Research still has yet to clearly indicate how the construct of culture affects this sequence within the African-American community. The extent to which African-Americans seek advice from friends and family members and help from healthcare professionals is largely unknown.

Anthropologists Flores (2000), Harwood (1981), and Pachter (1994) have also determined the impact of culture on clinical interactions. Flores examined the impact of five components of culture on clinical care: normative cultural values, language, folk illnesses, parent/patient beliefs, and provider practices. Most relevant to this study is the impact of normative cultural values—what Flores defines as "the beliefs, ideas, and behaviors that a particular cultural group values and expects in interpersonal interactions" with health care providers (2000:15). These beliefs have been synthesized from a combination of cultural beliefs and personal experiences and create individual health behaviors within cultural groups (Flores 2000). In addition, Harwood recognized that culture could impact the interactions between a physician and patient in healthcare visits, and coined the term *behavior ethnicity* to describe the "general styles of interaction, attitudes toward authority figures, sex-role allocations, and ways of expressing emotion and asking for help which are carried over into health-care situations" (1988:9). Behavior ethnicity impacts the interactions between health professionals and patients, and reactions to hospitals, clinics, and private practitioners. Because people in different cultural groups act differently as patients, they exhibit differences in the way they present symptoms, their expectations of physician behavior, their understanding of medical terms, and their responses to diagnoses and treatment regimens (Harwood 1988). While researchers have recognized that persons of lower socioeconomic status display vastly different behaviors than those of higher SES, few studies have examined the health practices of middle-class African-Americans; little is known about the behavior ethnicity of this population.

Because culture leads to differences in health perceptions and attitudes, it also creates differences in how cultural groups conceptualize health and treat illness. Consequently, physicians and patients often have different explanatory models for sickness, which can impact the physician-patient relationship (Pachter 1994). Pachter argues greater attention should be given to culturally mediated health beliefs and behaviors since ineffective communication between a physician and a patient can decrease the care they receive. Improving communication can improve compliance with therapeutic interventions and health outcomes for the patient (Pachter 1994).

Culture and ethnic group affect health behaviors in several ways. They impact the prescribed actions that a person takes once they recognize they are ill. These actions have been described as *illness behaviors,* or the different ways in which individuals perceive, evaluate, and treat illnesses (Harwood 1988). Although utilization of mainstream medical services is influenced by several factors, including class and organization of the delivery system, ethnic factors have impacted utilization in at least three ways: firstly, diverse ethnic groups often exhibit different patterns in seeking biomedical care; second, many ethnic groups support alternative providers of health care, who may be used prior to, in conjunction with, or following mainstream services; third, ethnic residential segregation causes persons to use medical services that are convenient to their residences, which often affects delivery of services (Harwood 1988:8-9). In addition, ethnic background has been shown to impact concepts of disease and illness in the following three ways: firstly, ethnic groups exhibit varying degrees of knowledge about biomedical categories of disease; second, ethnic groups may differ in the ways in which symptoms are classified into illness categories; and third, ethnicity has been shown to correlate with conceptions about the causes of disease and illness (Harwood 1988:9). Consequently, ethnically influenced concepts of disease and illness affect other areas of health behavior, including the evaluation of symptoms, utilization of non-mainstream medical services, and compliance with treatment regimens (Harwood 1988). Yet despite this awareness, the impact of ethnicity and culture on the health behaviors of college-educated African-American women has yet to be examined. Brondolo et al. adds ethnicity and race are complex variables that impact beliefs, behaviors, and access to resources. They also call for additional research,

> New models and analytic strategies are needed to help researchers understand the complex ways in which ethnicity affects health outcomes. Ethnicity may influence risk exposure, health behaviors, and coping resources. Different aspects of ethnicity-related variables (e.g., cultural beliefs, dietary habits, family structures) may exert effects at every point in the chain from stress exposure to health (2009:5).

Thus, further research needs to examine the impact of ethnicity on the beliefs and behaviors of college-educated African-American women.

The Homogenous Classification of African-Americans

Perceptions of health and illness are often more diverse within populations than research has documented. For example, research has predominantly focused on the disease perceptions of lower class African-Americans, omitting the beliefs of middle- and upper-class African-

Americans. This exclusion may depict African-Americans as being a homogenous ethnic or cultural group, an older model of thinking that Shoenberg (1997) warns against. Additional research is needed to understand a variety of folk models of illness so that more relevant treatment and prevention plans can be designed for individuals.

A homogenous classification of African-Americans also ignores the impact of age on health behaviors and attitudes. Previous research has determined factors that increased use of complementary and alternative medicine include age, lack of access to conventional care, cultural heritage, and dissatisfaction with conventional care (Barnett 2003 et al.; Barzargan et al. 2005). Ignoring the impact of age on health behaviors has done a disservice to the health care of African-Americans. Although medical research has only examined the health practices of one subpopulation of African-Americans, researchers have applied misrepresented data to the entire African-American community. It is imperative to understand the health behaviors and beliefs of older generations because they often transmit these practices to younger generations of African-Americans through cultural learning. Additional research needs to determine if cultural practices encourage utilization of biomedical care, alternative medicine, or both, especially since these behaviors can impact the health outcomes of African-Americans.

The homogenous classification of African-Americans in scientific literature has also presented a barrier toward reducing health disparities for this community. Greater attention has been given to the impact of cultural attitudes towards health care and health behaviors, but only among lower class African-Americans. The result is an alarming situation: we cannot fully reduce health disparities until we better understand the health disparities faced by all cultural subpopulations. This understanding requires examining racial, socioeconomic, and cultural factors to understand their impact on the health of minorities. This belief is also shared by

Randall who comments, “Failure to consider intra-ethnic diversity may lead to erroneous conclusions about African-American health” (1993: 134). Jackson (1988) adds additional studies need to examine large differences between the health behaviors of northern and southern blacks; urban and rural blacks; and native and foreign-born blacks. Current perceptions of the health behaviors of African-Americans are inaccurate because they have only examined the health practices of lower-income African-Americans. As highlighted by Williams, “There is considerable heterogeneity within each of the major racial/ethnic populations that importantly predicts variation in health status within each group” (1999:174). Because research has seldom examined this heterogeneity, the health behaviors of diverse African-American populations are still not entirely understood.

More consideration of intraethnic diversity may reduce how frequently ethnicity is cited as the only influence on the health practices of diverse subpopulations, or may at least reveal when ethnicity is or is not significant. All individuals in a cultural group do not think and act in the same way; an individual’s health beliefs and practices arise from a combination of cultural values with personal experience and perceptions (Flores 2000). A greater awareness of not only subgroup variation, but also variation among individuals is essential. Pachter adds:

> A goal of culturally sensitive health care is to acknowledge that health care decisions are made by individuals—not groups. There is often as much intracultural variation in beliefs and behaviors as there is interculturally. The culturally sensitive clinician must be aware that there exist certain beliefs within a group, and then determine to what extent these beliefs may be acted on by a specific patient during a specific illness episode (1997:693).

Little information is available on intraethnic variation in the health behaviors of African-Americans because researchers only highlighted folk practices shaped by social class, and generalized behaviors to a whole ethnic group, even though differences exists (Harwood 1988).

Clark et al. state, “There has been less research exploring associations between perceived racism, other sociodemographic factors, and health outcomes. For example, age and gender may influence health outcomes” (1999:808).

Factors Influencing Selection of a Healthcare Provider

There is growing evidence that minority patients disproportionately receive care from minority physicians (Cooper-Patrick et al. 1999; Gray and Stoddard 1997; LaVeist and Nuru-Jeter 2002; Moy and Bartman 1995). Despite the small number of minority physicians, minority patients are more likely than Caucasians to be treated by a minority physician. Research has documented a high percentage of African-Americans seek care from African-American physicians due to a preference for a same-race physician (Gray and Stoddard 1997; Moy 1995). Gray and Stoddard examined whether African-American patients sought care from African-American physicians since these physicians are more likely to treat Medicare patients, and Medicare patients are disproportionately black. They were able to isolate the independent effect of provider's race/ethnicity—as opposed to other physician characteristics—on physician matching. According to Gray and Stoddard, this was an important correction,

> Because it allows for measurement of the independent influence of race/ethnicity on patient physician matching...By decoupling the impact of these other factors, we have shown that race/ethnicity is an independently important predictor of physician race/ethnicity, although controlling for other factors does explain about half of the correlation between patient and physician race/ethnicity. This suggests that the racial matching is the result of actual physician and/or patient preferences (possibly reflecting cultural competence) and not simply an artifact of minority physicians disproportionately providing care to low-income patients. This has strong policy implications because it suggests that demand for minority physicians is in part independently determined by racial/ethnic make up of society regardless of socioeconomic class (1997:257).

While this documentation is valid for its separation of the impact of race/ethnicity and social class on physician preference, it is based on the assumptions that race/ethnicity impacts access to regular care, which in turn influences preferences for the race/ethnicity of a provider. However, this assumption may not be equally applicable to middle- and upper-class African-Americans who do not experience the same barriers to care as lower-income African-Americans (Politzer et al. 2001). In addition, this study did not examine the impact of other factors on race of physician, especially age.

Additional research has given greater insight into the factors that affect preference for a same-race physician within the African-American community. One study examined this preference across a wider range of socioeconomic classes, and determined preference for same-race physician increased as income level increased (Malat and Hamilton 2006). However, older age decreased preference for a same-race physician; persons over the age of fifty-five had the lowest preferences for an African-American physician (Malat and Hamilton 2006).

An increasing number of studies are also beginning to investigate gender preferences for physicians of African-American women in addition to racial preferences. One study explored the factors important to 19- to 24-year-old African-American women in choosing a healthcare provider, and found female providers were favored, but race was not of primary concern (Dale et al. 2010). Participants expressed preference for female providers, due to increased trust and comfort. However, the study only focused on women who were served by safety net and public programs such as WIC, local health departments, and community health clinics; the research findings represent only low-income young African-American women. Dale et al. (2010) even admit that African-American women of different income levels might have different perceptions and beliefs. Similarly to Dale et al., García et al. (2003) also determined African-American women valued gender concordance more than race concordance with their provider, as female providers were believed to provide comfort and be more accommodating and knowledgeable about problems encountered by women. This was also one of the first studies where African-American participants expressed a preference for African-American physicians even though their regular health provider at a public clinic was not black. However, their findings did not denote the impact of socioeconomic status or age on these preferences. A different study evaluated the influence of racial and gender concordance on perceived similarity with provider (Street et al., 2008). The study concluded that 58% of the sample was concordant with respect to sex, and 32% was racially concordant. This study provided even less information about the preferences of subpopulations of African-Americans, as researchers classified the preferences of all African-American participants in the same category. Thus, additional research needs to outline the gender and racial preferences for regular healthcare providers among college-educated African-American women.

Folk Medicine/Ethnomedicine

Previous ethnographic and community-based studies have outlined the ways different ethnic groups treat their illnesses with biomedical and alternative medicine.[2] While use of alternative medicine among lower class African-Americans has been documented (Bailey 1988; Barnett et al. 2003; Barzargan et al. 2005; Bogart 2001; Brown and Segal 1996; Heurtin-Roberts 2002; Schoenberg 1997; Snow 1993), the extent to which middle class African-Americans rely on folk medicine is unknown. It is also unknown if such care complements biomedical care or

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[2] This thesis will use "alternative medicine" to refer to any treatments outside of seeking a physician, taking prescribed medication, and following physician recommendations. Alternative medicine includes folk medicine, self-treatment, religious/spiritual healers, vitamin therapy, over-the-counter medicine, etc. Folk medicine will reference treatments used by African-Americans that are distinct from the universal practices of biomedicine, such as home remedies.

replaces it as it does in lower class African-American communities. Research needs to not only document use of alternative medicine, but also determine whether its usage interferes with or decreases an individual's willingness to seek appropriate professional care.

It is essential to determine how college-educated African-Americans treat themselves with self-care and folk medicine for several reasons. One key reason is that they "remain important but largely unknown components of health-seeking behaviors among under-served minority populations" (Barzargan et al. 2005:531). While research has recognized that self-care offers health care to individuals with limited access to health care, rates of self-care among populations that experience greater access to health care have been examined less frequently. Studies have only concluded that various ethnic groups utilize alternative treatments at different frequencies (Barnett et al. 2003). Consequently, the frequencies at which college-educated African-American women utilize self-care and folk medicine still remain largely unknown. Because information on current habits of self-medication and health maintenance can be used to develop more effective treatment plans (Harwood 1988), this represents an enormous gap in the healthcare literature.

Urban blacks have historically relied heavily on folk medicine for the treatment of some illnesses or utilized folk and biomedicine simultaneously (Jackson 1988:37). Despite the high respect given to health care providers, integration within the "biomedical mainstream", good access to health facilities, high utilization rates, and relatively strong adherence to recommended treatments, researchers have continued to document a heavy reliance on folk practices (Shoenberg 1997). Shoenberg also discovered that the impact of health beliefs on adherence to treatment recommendations remains complex—often a mix between "traditional" and biomedical health recommendations and practices; there remains a "dual efficacy of mainstream medical treatment and popular treatments like home remedies and religious healing" (1997:177). Folk healers[3] present both problems and benefits to health professionals. Problems include delayed seeking of care from a physician, use of alternative remedies, and noncompliance with prescribed treatments. However, if physicians are aware of and accepting of folk treatments, they may be able to combine folk and biomedical systems in a way that can benefit the patient. Effective interventions cannot be designed until folk health practices of contemporary African-Americans are better documented.

Given the documented reliance of African-Americans on folk (or lay) models of disease and illness within the lower-class African-American community, additional folk models must be researched for their impact on African-Americans' health. Bailey (1988) strongly recommends understanding the individual's perception of "health" and "illness" before an appropriate treatment can be suggested. Thus, health beliefs and practices within the African-American community need to be better understood if health providers plan to offer relevant treatments that patients will adhere to over time. This is especially the case with widespread and potentially fatal diseases, such as hypertension. Bailey also detailed family and friends had a stronger influence on health beliefs than health professionals when there was limited access to care. Therefore, this research will describe the impact of friends and family on health beliefs and practices among the study participants.

In order to understand the health behaviors of African-Americans, we must understand how culture facilitates the transmission of health and illness behaviors from one generation to the next. Concepts of disease and illness are largely learned through direct experience (Jackson

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[3] According to Barzargan et al. (2005), folk healers include Christian faith healers and other spiritual healers (curandero, voodoo, mystic). Williams and Mohammed (2009) also includes root doctors, herbalists, and midwives as folk healers.

1988). Older blacks, who utilize both folk and biomedical traditions, have transmitted these cultural health practices to younger generations as a substitute for seeking care from a physician due to the historical exclusion of blacks from mainstream medicine (Jackson 1988). Further research needs to examine the extent to which these culturally transmitted practices are followed by younger generations.

Further knowledge of how African-Americans treat disease is especially key to negate any negative interactions between alternative medicine and biomedical care. Pachter stated, “Another reason why medical personnel need to be aware of folk illness beliefs is because some folk practices and treatments may be potentially hazardous. It is uncommon for folk remedies to cause major adverse effects, but occasional examples have been reported, and the potential for serious harm does exist” (1994:691). Flores similarly argued, “Patient beliefs can have a profound impact on clinical care. They can impede preventive efforts, delay or complicate medical care, and result in the use of neutral or harmful remedies” (2000:19). There is much more that we need to examine about the nature and efficacy of therapeutics and decision-making in the popular health care sector (Kleinman et al. 1978). Physicians should also recognize the possible benefits from alternative medicine rather than just dismissing their efficacy.

The Intersection of Social Class, Race, and Health

While studies have documented the usage of folk medicine practices within the African-American community, they have seldom examined the reasons these practices are still used today. Research has shown that increasing SES among blacks and whites has improved health outcomes and reliance on biomedical care (Williams and Collins 1995). Limited research on the health behaviors of middle-class blacks has shown they are more influenced by biomedical knowledge than lower-class blacks, but may also misinterpret symptoms more frequently (Jackson 1988). Low-income blacks may seek help more quickly than blacks in higher social classes due to lower cost of care through government subsidies, despite not having full-time employment (1988). However, the opposite may be true; middle-class blacks may be more likely to seek care than lower class blacks due to greater access to care and greater reliance on biomedical knowledge for care outside the physician's office. Further research needs to examine the impact of higher social class on the health behaviors of African-Americans, particularly to separate the impact of culture on health behaviors from that of social class[4] and race.

While anthropological literature comprehensively recognizes that culture impacts health behaviors, it does not report if the impact is the same across all socioeconomic classes of black women. For example, Newman et. al, (2002) identified African-American ethnicity as an independent predictor of a less positive breast cancer outcome, but did not observe the extent to which higher SES helps to reduce these poor health outcomes for African-American women. This is a grave omission, as it is recognized that higher social class results in improved health outcomes (LaVeist 2005). This perception also links health outcomes to race instead of examining all of the underlying factors for poor disease outcomes among African-American women. Not all African-Americans face the same health risks or have the same health behaviors. This research will demonstrate that the health behaviors, attitudes, and perceptions of college-educated African-American women differ from that of African-American women with lower educational levels.

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[4] This research will utilize LaVeist's (2005) definition of social class as "groupings of individuals based on their relationship to the economy". Social class impacts access to resources, such as health care, and is determined by ethnic group, religious affiliation, education, occupation, etc. Within the African-American community, however, higher SES is not always synonymous with higher social class, as national data reveals large racial differences in wealth (Williams 1999).

Chapter 2: Background and Literature Review

This research examines the health behaviors and beliefs of college-educated African-American women in order to determine differences in these behaviors across generations. Because health behaviors and beliefs are predominantly shaped by culture, this work investigates cultural health behaviors (how this population prevents sickness), illness behaviors (how this population treats sickness), and racial and gender preferences for physician across generations. Background information on the historical exclusion of African-Americans from mainstream health care, medical mistrust, health disparities, satisfaction with care, and experiences of racial discrimination must be addressed in order to frame this research project. In addition, folk medicinal practices will be further discussed in order to illuminate its role in shaping the health behaviors and beliefs of this population. This chapter will examine some of the factors that have indirectly impacted the health behaviors and beliefs of African-Americans, as well as discuss how medical anthropology can help us better understand the health practices and attitudes of college-educated African-American women.

A History of the Exclusion of African-Americans from Mainstream Health Care

Caste, race, and class problems have distorted the nation's healthcare system from its very beginnings (Byrd and Clayton 2000). Historically, health care for African-Americans has been characterized by discrimination, medical abuse, limited access to healthcare facilities and unequal treatment (Byrd and Clayton 2000). The oldest participants in this study were born in the 1920s; by this decade, the infrastructure of the health system had been established on the basis of racial segregation and class exclusivity. Most hospitals at this time either refused to treat blacks or conceptualized them as inhuman. Post-Civil War black medical schools and the few black hospitals and clinics in existence were the only medical institutions in the US that even viewed blacks as normal human beings (Byrd and Clayton 2000). As described by LaVeist and Nuru-Jeter,

> Through most of the twentieth century, the treatment of racial and ethnic minorities within healthcare settings was dictated by a set of customs spawned by the American racial caste system and enforced by governmental policies. Healthcare facilities were racially segregated. Nonwhite patients received substandard care. Interpersonal communications during medical encounters between patients and healthcare providers of different racial and ethnic groups were discourteous to minorities (2002:296-297).

During most of the 1900s, African-Americans were treated at federally funded, racially segregated healthcare facilities. They not only received inferior care but also were discriminated against by white healthcare providers. Such treatment continued to perpetuate health disparities until the 1960s. Byrd and Clayton describe the changes that occurred at this time, "The 1964 Civil Rights Act, hospital desegregation rulings in the federal courts, passage of Medicare and Medicaid, passage of the Voting Rights Bill, and the community health center movement created a *Civil Rights Era* in health care for African Americans" (2000:17). Unfortunately, US hospitals were not desegregated and efforts were not made by the government to improve the health care of African-Americans prior to 1964. Despite the passage of these federal policies, there was little improvement in the health of blacks aside for one area: a dramatic increase in the health status of blacks due to increased access to health care (Byrd and Clayton 2000). However, this progress ceased in 1975 due to the reallocation of federal funding to other projects. Consequently, black health status deteriorated relative to whites after 1980 with "African Americans continuing to suffer excess morbidity and mortality and having the highest death rates in 12 of the 15 leading causes of death" (Byrd and Clayton 2000:17). Subsequently, "disparate health care treatment and quality based on race and class are an American tradition that has been transmitted into the twenty-first century" (Byrd and Clayton 2000:30).

Feelings of Mistrust in the Healthcare System

A consequence of the historical exclusion of blacks from mainstream healthcare has been the resulting distrust of the medical care system among African-Americans (LaVeist et al. 2000). Contributing to this medical mistrust has been widespread knowledge of the Tuskegee Syphilis Experiment—the forty-year (1932-1972) study in which 399 illiterate, poor black men from Macon County, Alabama were purposely denied treatment in order to document the natural course of the disease. The experiment was funded by the federal government and participants were not informed that they would not be receiving treatment but would only be given placebo treatment. The experiment had devastating consequences for not only those individual's health, but also and trust in biomedical care throughout the larger African-American community. Following public disclosure in 1972, the experiment progressed from being an insolated historical event to a powerful metaphor, symbolizing "racism in medicine, misconduct in human research, the arrogance of physicians, and government abuse of black people" (Gamble 1997:1773). Numerous articles in both professional and popular press have stated that the study not only caused many African-Americans to distrust medical and public health authorities but also resulted in extremely low black participation in clinical trials and organ donation (Gamble 1997). While many describe the study as the singular reason behind African-American distrust of medicinal and public health institutions, Gamble argues that such an interpretation deemphasizes the fact that mistrust predated public revelations about the Tuskegee study. Deeply entrenched and complex attitudes within the black community cannot be understood without an examination of the historical and social factors that have influenced, and continue to influence, African-

Americans’ attitudes toward the biomedical community. Mistrust also impacts how African-Americans perceive their health care,

> African Americans’ beliefs that their lives are devalued by white society also influence their relationships with the medical profession. They perceive, at times correctly, that they are treated differently in the health care system solely because of their race, and such perceptions fuel mistrust of the medical profession. The powerful legacy of the Tuskegee Syphilis Study endures, in part, because the racism and disrespect for black lives that it entailed mirror black people's contemporary experiences with the medical profession. The Tuskegee Syphilis Study continues to cast its shadow over the lives of African-Americans (Gamble 1997:1777).

This finding is significant because Gamble articulates that the presence of racism in the larger American society often causes African-Americans to (correctly) perceive that physicians treat them differently solely on the basis of their race. These perceptions still promote feelings of mistrust in the medical system because they continue to be experienced by contemporary blacks; they are not mere isolated instances encountered by blacks in the past. Gamble concludes, “The problem we must face is not just the shadow of Tuskegee but the shadow of racism that so profoundly affects the lives and beliefs of all people in this country” (1997:1777). Although the Tuskegee Experiment was an unfortunate event, it was only one racist incident out of several in the lived experiences of African-Americans that continues to fuel mistrust in the healthcare system today.

A Propagation of Health Disparities

Another unfortunate consequence of the historical exclusion of blacks from adequate care has been the high prevalence of health disparities in this community. The term *health disparities* refers to “preventable differences in the health indicators of different population groups, often defined by race/ethnicity, sex, educational level, income, socioeconomic status, and geographic location of residence" (Mensah and Glover 2007:22-23). As the definition implies, health disparities have been documented for a number of populations. This section will frame the history of health disparities faced by the African-American community, for it helps explain the reasons this population continues to face health problems today.

Disparities in healthcare are not a recent development but a propagation of the inequality that African-Americans have experienced since slavery (Williams 2007). One of the predominant reasons this occurred was the widespread historical classification of blacks as a separate species from whites. Also at this time, scientific research began documenting differences in the health status of blacks and whites to display the natural superiority of whites. Particularly debilitating was the work of Dr. Samuel A. Cartwright who stated, "Blacks were inherently inferior and possessed defects of the nervous and cardiovascular systems, making them susceptible to diseases such as syphilis, yaws and degeneration of the circulatory system" (Williams 2007:15). For most of history, African-Americans were viewed as an inferior race with a natural susceptibility to diseases. Consequently, physicians either did not bother to treat their illnesses or offered unequal care to that given to whites.

The US federal government even supported laws that perpetuated unequal care for African-Americans throughout history. As documented by Williams, "when the Dred Scott decision was handed down [in 1857], it gave official, scientific, and legal approval by the federal government for slavery and poor healthcare delivery to blacks" (2007:8). Following this period, ex-slaves attempted to improve their health care through the Freedman's Bureau, which built hospitals and gave medical assistance to blacks (Williams 2007). However, progress towards greater care for blacks was halted in 1872 with the dissolving of the Freedman's Bureau. The subsequent form of health care supported by the government was "separate but equal" facilities, which perpetuated unequal care to blacks. Additionally, all but two of the eleven medical schools for blacks were closed by 1910, per government recommendation (Williams 2007). This further limited access to care for blacks. In 1964, the passage of the Civil Rights Act declared "separate but equal" facilities illegal and prohibited racial discrimination in public facilities (hospitals), ending federal funds for hospital segregation (Williams 2007).

Discrimination continued even though it was outlawed by legislation, as few penalties were given to those who violated desegregation laws. During the 1960s, "blatant segregation metamorphisized into subtle discrimination within the healthcare system; racism continued to prevail despite all of the putative legal gains and civil rights advances" (Williams 2007:13). The current state of the health care system is a form of *de facto* segregation in healthcare delivery – a form of institutionalized racism that continues to deny most African-Americans health care. High quality hospitals reject poor minority patients by refusing to accept Medicare or treat patients without insurance coverage. As a result, health care for lower-class blacks is largely concentrated in urban ghettos at large municipal centers that are severely overcrowded and underfunded. In contrast, greater financial security has allotted middle- and upper-class African-Americans better access to health care than given to lower-class African-Americans (Politzer et al. 2001). However, disparities are still documented for these populations due to continued practices of racial discrimination. As argued by Myers,

> At the core of the ethnic health disparities is differential exposure to psychosocial adversities moderated by inadequate access to and control over essential material, psychological, social, and health care resources over time…This disadvantaged health relationship is further maintained and enhanced through debilitating social environments (i.e. poverty and poor health care), and mediated through biological, behavioral and psychological pathways. The interplay of these factors is hypothesized to result in cumulative biopsychosocial vulnerability over the life span, which accounts, at least in part, for the cross-generational persistence of the health disparities that is documented in the epidemiologic literature (2009:10).

Health disparities continue to decrease the health of all generations of African-Americans by increasing their vulnerability to disease and decreasing their access to healthcare resources. Although middle-class blacks have been afforded greater material, psychological, social, and health care resources, they continue to suffer negative health outcomes due to racial discrimination. Additional research is needed to further examine the impact of racial discrimination on the health behaviors and perceptions of the black middle class.

The Establishment and Continuation of Folk Medicinal Practices and Folk Beliefs

The historical lack of federal and state support for a medical care system for blacks often confined them to treatment by root doctors, herbalists, midwives, voodoo (Williams and Mohammed 2009) and the propagated the usage of home remedies and other folk practices (Barnett et al. 2003). Barzargan et al. (2005) examined eleven predisposing characteristics to better identify the population that continues to use alternative medicine. These characteristics were: age, gender, ethnicity, employment status, education, family size, English proficiency, perceived racial discrimination, and health locus of control (the ability of an individual to treat himself). Participants were surveyed to understand practices used for prevention, treatment, and substitution of biomedical care. Final analyses determined the use of alternative care for prevention was most associated with higher education, greater perceived racial discrimination, and poorer health status. The use of alternative care for treatment was most associated with greater perception of racial discrimination, greater financial strain, and poorer health status. Prayer was the most frequently used form of alternative care; followed by traditional remedies, over-the-counter medication, home remedies, and herbal remedies. These practices were most often used to treat sickness, but least often used to substitute for biomedical health care. The use of alternative care as a substitute for conventional care was most associated with the following four variables: “1) reduced belief that powerful individuals (such as physicians or other health professionals) control one’s health; 2) greater perceived racial discrimination; 3) greater financial strain; and 4) reduced access to medical care” (Barzargan et al. 2005:535). Barzargan et al. concludes with a recommendation for more research that examines the usage of alternative medicine as a substitute for conventional care and/or disease prevention. Given the conclusion that higher education was associated with self-treatment, additional research needs to examine the frequency at which college-educated African-American women treat themselves.

Several research disciplines have investigated the underlying cultural factors impacting health decision-making to better understand the impact of these factors on morbidity and mortality rates. Most research outlining the impact of health beliefs within the African-American community has focused on compliance with recommended treatment for hypertension or recognition of its symptoms (Bailey 1988; Heurtin-Roberts 2002; Schoenberg 1997). These studies have also provided recommendations to researchers, health care providers, and policy makers for the elimination of health disparities and improvement of health outcomes; they argue that understanding cultural beliefs and practices can improve health care for African-Americans. All three studies recognized that individuals craft explanations for illness and rationalize treatments within a culturally constructed environment. Individuals are also influenced by others in their environment; concepts of sickness and health include both the individuals’ perceptions and the perceptions of others. Heurtin-Roberts states individuals consolidate multiple cultural viewpoints into a single “folk model of illness, a useful, symbolic construct summing and expressing more diverse, individually held beliefs” (2002:286). Appreciating folk models can be helpful when treating patients, as they may include beliefs held by community members that stand in contrast to biomedical knowledge.

Research on lower-class African-Americans with hypertension has identified folk illnesses separate from the biomedical condition of hypertension. Heurtin-Roberts (2002) identified two widespread folk illnesses: "high-pertension", caused by "nerves", and "high blood"[5], a physical malady. Study participants described high blood as a " 'disease of the blood and heart' ", causing excessively " 'hot', 'thick', or 'rich' blood" to rise up in the body and remain " 'elevated' ". The illness was also said to " 'work on the heart too hard' ". Participants stated normal blood is "at rest" or "quiet", and therefore lower in the body, but when "pressure trouble" occurs, the blood rises up through the body towards the head. Participants felt high blood was very dangerous and bad for one's health and well being. Causal and exacerbating factors of high blood include: eating too much "wrong food" (e.g. pork, salt "seasoning", and "grease"); heredity; heat; and stress. Participants stated effective treatment for high blood includes physician-prescribed antihypertensive medication, dietary control, and, less importantly, weight loss. Participants also believed the previously mentioned treatments could be supplemented with home remedies of garlic, lemon, and vinegar[6].

In contrast, participants believed that during "high-pertension" the blood is initially at rest, but rapidly rises and falls during periods of intense emotion; it "accelerates" (versus "elevating" in high blood). High-pertension is supposedly caused by " 'bad nerves', stress, worry, and anger". Medication, dietary, and weight loss were not believed to be very effective in managing

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[5] The study participants of Bailey (1988) also gave a similar description for 'high blood' but cited additional causes of high blood such as inadequate rest, weather disturbances, poor nutrition, and imbalances in body temperature.

[6] Additional home remedies utilized by informants included: Epsom salts, sassafras tea, aloe, and cream of tartar (Bailey 1988; Shoenberg 1997). Such treatments were said to lower blood pressure and flush the body of impurities (Bailey 1988). Treatments by folk healers included: religious rituals, herbs and roots, and certain prohibitions or directions given to cure persons (Bailey 1988).

high-pertension. Instead, study participants recommended the individual “avoid worrying, relax, rest, stay quiet, and get away from people” (2002:290). High-pertension was thought to be unpredictable and episodic, and therefore, more dangerous than high blood. Some women even believed hysterectomy and menopause exacerbate high blood and high-pertension by increasing blood flow to the head and agravating one's “pressure troubles”. Participants also recognized links between environmental conditions and worsening health. One study participant described, “One's blood rises with the problems of the world, at times it boils up and almost spills over. One's worries, fears, angers, and frustrations accumulate as does one's perceived inability to cope with them, damaging the body and ultimately resulting in death” (290).

Research has identified additional folk practices of African-Americans. Citing Snow (1977) and Teish (1985), Bailey comments that the ethnomedical beliefs and practices of African-Americans have been derived from a variety of sources:

> European folklore, Greek classical medicine, modern scientific medicine, and particularly African folklore. These diverse threads are tied together by the tenets of fundamentalist Christianity, elements from the voodoo religion of Haiti, and the added spice of sympathetic magic (1988:1105).

Bailey’s research is particularly alarming for its finding that African-American participants perceived emotional worry as the major cause of high blood pressure and believed that their blood pressure would return to normal after their psychosocial stress was alleviated. He found black participants were also significantly more likely than white participants to believe they could detect when their blood pressure was elevated and detailed symptoms that manifest when blood pressure is elevated (i.e., headaches, dizziness, nausea), despite the publicized biomedical depiction of hypertension as the symptomless “silent killer”[7]. These informants subsequently discontinued their antihypertensive medication to rely on an “ethnocare approach (‘folk’ or ‘emic’ caring practices)” to diagnose their major stressors. These ethnocare approaches could also include treatment by a folk health practitioner (such as herbalists, neighborhood prophets, and magic store vendors) over a medically-trained physician. Bailey concluded such a response was also a symbolic gesture; African-American participants used ethnic health care practices to avoid depending on mainstream antihypertensive medication. He discovered additional reasons for seeking folk health practitioners for treatment included: “1) to cope with health problems within the context of their own resources and social environment, 2) to cure illnesses caused by forces of misfortune which are believed to be outside of the knowledge of westernized medical physicians, 3) such treatment is less expensive than traditional medical treatment” (Bailey 1988:1111).

Heurtin-Roberts (2002) also discussed the cultural symbolism attached to hypertension by the African-American community. Positive diagnosis of high-pertension indicates one is anxious, angry, or grieving. The disease offers an acceptable means of expression of these emotions within the African-American community, as these negative emotions are not valued traits of a mother or homemaker. High-pertension also offers a “release from social norms which would govern a younger woman in good health. By virtue of high-pertension, a woman is given increased freedom and power to act”—a recognition that not all problems can fall on the black woman and that others must share social responsibility in child-rearing and housekeeping (2002:291). High-pertension is also a “culturally stylized illness which allows behavioral change

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[7] Shoenberg (1997) also documented the widespread belief within the African-American community that hypertension does present symptoms and can be dissipated by behavioral changes, praying, going to church, and reading the Bible.

that would otherwise be frowned upon…It allows women to at least partially put the role of caretaker behind, and to acknowledge personal needs for care and to legitimately tend to one's own well being" (291). Heurtin-Roberts cautions,

> If certain beliefs about an illness have adaptive worth, persons may loathe to relinquish them, limiting the prospects for successful biomedical health education. There may also be reluctance to manage illness to the point that it is not threatening, because the ill person then loses what little control is possessed over the environment (2002:293).

As a result, lower-class African-American women may be reluctant to treat their illnesses fully because it allows them greater ability to control their environment and dictate the tasks that they can and cannot do. This cultural perception could present a barrier to seeking biomedical care or compliance with recommended treatment. Because this perception has been associated with low SES, increases in status should result in greater reliance on mainstream health care and compliance with medical advice. However, this cannot be concluded because very few studies have examined the health behaviors of college-educated African-American women. This research seeks to examine the extent to which college-educated African-American women continue to rely on folk medicine practices and folk knowledge to prevent and treat their sickness episodes.

The Impact of Racial Discrimination on the Health Care of Contemporary African-American Women

The impact of racial discrimination on the African-American community is extensive. It not only affects the health and health care of African-Americans, but also is one of the underlying contributors to the health behaviors and perceptions held by most of the members of this community (Barzargan et al. 2005; Benkert et al. 2006; Blanchard and Lurie 2004; Brondolo et al. 2009; Burgess et al. 2008; Casagrande et al. 2007; Chen et al. 2005; Hausmann et al. 2008; Karlsen and Nazroo 2002; LaVeist et al. 2000; Sorkin et al. 2010; Trivedi and Ayanian 2006). Racism also takes a physical toll on the body, widening the health disparities faced by African-American women. It is for these reasons that a summary of the impact of racial discrimination is given here; discrimination is a subset of race/ethnicity that impacts all socioeconomic classes of African-American women. In addition, studies predominantly have assessed the impact of racial discrimination on the health behaviors and health care of lower class African-Americans (Barzargan et al. 2005; Benkert et al. 2006; Casagrande et al. 2007; Hausmann et al. 2008; LaVeist et al. 2000; Sorkin et al. 2010); its impact on middle- and upper-classes of African-Americans is less known.

The manifestation of racial discrimination and racism in the African-American community has changed throughout US history. Discrimination[8] can be classified into two main, but not mutually exclusive, categories: interpersonal and institutional (Karlsen and Nazroo 2002). Racism is defined as “beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation” (Clark et al. 1999:805). Before the Civil Rights Movement, experiences of interpersonal and institutional discrimination by African-Americans were a frequent occurrence that resulted in the exclusion of African-Americans from majority-white American society. However, most of the discrimination faced by African-Americans now is far subtler, almost covert (Williams 2007).

As a subset of racial discrimination, vigilance is another factor that impacts health care and health behaviors. Due to the more invisible nature of racial discrimination following the Civil Rights Movement, vigilance increased to help African-Americans anticipate and respond to acts

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[8] This research will use Hausmann et al.’s (2008) definition of discrimination as treatment of one group that is inferior or lower in quality than the treatment of another group.

of discrimination. According to Williams,

> Vigilance regarding the threat of discrimination and the anticipation of future occurrences of discrimination could be as predictive of the adverse health impact as the actual effects of past discriminatory experiences. The negative physiological effects of exposure to stressors are often triggered by the initial perception of threat, which can occur long before the actual exposure to the stressor (2009:34).

Vigilance deepens the toll of racial discrimination on the body. Even if African-Americans do not experience interpersonal discrimination, they will still manifest effects of racial discrimination through constantly waiting for someone to be prejudiced against them. Vigilance may also manifest itself in perceived-inferior health interactions between black patients and white physicians. Such perceptions may prevent patients from sharing pertinent health information with providers for fear of stigma. More research is needed to determine if fear of discrimination and hyper-vigilance in anticipation of discrimination prevents patients from openly sharing health information with physicians or seeking biomedical care. Such a physician-patient relationship, in which trust is limited, can reduce the quality of care middle-class blacks receive, even if they do not experience limited access to health care. This discrimination can also impact racial preference for a physician or cause an individual to prolong seeking preventative and/or therapeutic care to avoid discriminatory situations (Barzargan et al. 2005; Burgess et al. 2008; Chen et al. 2005).

Research has also found racial discrimination is a psychosocial stressor that worsens heath outcomes (i.e. morbidity and mortality rates), thus exacerbating health disparities (Clark et al. 1999). The cumulative impact on the health outcomes on the entire African-American community is quite large. Racial discrimination has worsened drug and alcohol abuse and triggered African-Americans to resort to “unhealthy behaviors” to cope with the stress caused by racism (Williams and Mohammed 2009). Discrimination also affects access to care, quality and intensity of medical treatment, and the quality of health care providers. However, these consequences are mainly due to the low socioeconomic status of most African-Americans. It is very worrisome that higher social class does not appear to reduce the negative impact of racial discrimination on health outcomes. For example, the infant mortality rate for college-educated black women was 10.2 per 1,000 live births but 5.4 per 1,000 for college-educated white women (Schoendorf et al., 1992). The infant mortality rates of college-educated black women are also higher than those reported for the general black population (Schoendorf et al., 1992). Studies have concluded the high frequency of low-birth-weight infants among this population is due to the impact of perceived racial discrimination (David and Collins 2008; Jackson et al. 2001). Because it is also more damaging to one's health to internalize events of racism and accept unfair treatment, women stand to suffer more health consequences for they are more accepting of an inferior status than men (Armstead et al. 1989). Thus higher socioeconomic status may not allow women to escape the impact of racial discrimination on their health.

Limited opportunities are not only experienced among lower-class blacks, but also middle-class blacks. Unique to the black middle class is the token stress and social rejection that they experience in the workplace (Jackson and Stewart 2003). Such stressors have negatively impacted the mental health of this population. They argue, "upward mobility among racial/ethnic minorities does not automatically result in full social acceptance by others" (Jackson 2003:442). Because social mobility has not exempted blacks from discrimination in the workplace, it may similarly not afford them escape from discrimination during healthcare encounters.

Results of studies examining the frequency of racial discrimination by participant sociodemographics have been inconclusive. For the most part, reported rates of interpersonal discrimination while seeking health care have been low but, when experienced, discrimination was shown to impact health care and health behaviors. Despite the low frequency at which discrimination was reported, some studies determined African-Americans were more likely than whites to report racial discrimination after controlling for a variety of background characteristics (Blanchard and Lurie 2004; Hausmann et al. 2008; LaVeist et al. 2000). In contrast, other studies did not determine racial differences in the reported rates of discrimination in health care (Trivedi and Ayanian 2006; Casagrande et al. 2007). Other research concluded that persons with a high school education or less were more likely to report experiencing discrimination (Blanchard and Lurie 2004; Hausmann et al. 2008; LaVeist et al. 2000)[9]. Another study found men more likely than women and minorities more likely than whites to report being treated with disrespect due to their race (Blanchard and Lurie 2004).

Perceived racial discrimination has also been associated with worse health status (Hausmann et al. 2008; Trivedi and Ayanian 2006). In the study performed by Trivedi and Ayanian (2006), racial discrimination did not appear to impact use of preventative services. However, other studies that similarly observed the relationship between perceived discrimination, delays in seeking medical care and adherence to medical recommendations determined that higher rates of perceived discrimination increased delays in seeking care and nonadherence to prescribed medical treatment (Burgess et al. 2008; Casagrande et al. 2007). Blanchard and Lurie (2004) additionally concluded those who reported that they were treated unfairly because of race were less likely to get a routine physical exam, follow physician advice, or receive appropriate secondary preventive care for diabetes, heart disease, and hypertension. Additional work determined perceived discrimination greatly contributed to use of preventative medicine (Bargarzan et al. 2005).

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[9] It is expected that reported rates of discrimination from study participants will be quite low since college-educated participants were less likely to report experiencing discrimination than participants with less education.

These findings suggest that one of the ways that perceived racial discrimination may lead to poorer health outcomes for minorities is through decreased use of biomedical care. Additionally, greater perceived discrimination decreases satisfaction with care (LaVeist et al. 2000), which may make patients more likely to self-medicate themselves. Everyday discrimination, but not healthcare discrimination or isolated incidences of discrimination, led to underutilization of medical care by US-born blacks in a study conducted by Burgess et al. (2008). Researchers speculated,

> It may be the case that experiences of discrimination and unfair treatment engender negative expectations among ethnic minorities and other socially disadvantaged groups about how they will be treated within large institutions and/or by members of the dominant culture, making them wary of entering such encounters (Burgess et al. 2008:906).

Thus, greater perceived discrimination can impact care even if a patient does not experience discrimination from a provider.

Experiences of discrimination inside and outside the healthcare setting may jeopardize care for medically needy patients, but the impact on less needy patients is unclear. As Hausmann et al. (2008) and Casagrande et al. (2007) predominantly sampled lower-income African-Americans, the perceived rates of racial discrimination in healthcare settings by middle-class African-Americans are still not known. Further studies need to identify groups most at risk to encounter discrimination in health care settings for the impact of discrimination on health and health behaviors.

Satisfaction with Care

Satisfaction has been studied recently for its impact on the health behaviors and beliefs on African-American women. Although this research will indirectly measure how satisfied study participants are with their health care, this is still a variable that needs to be better understood as it can decrease reliance on biomedical care and adherence to physician recommendations, and ruin physician-patient relationships. Those reporting less satisfaction with care are more likely to highly value self-treatment. Past events causing low satisfaction with care need to be documented to help identify and understand instances that have increased reliance on alternative medicine.

The Role of Physician-Patient Concordance in Satisfaction with Care

Research that has compared the overall satisfaction with health care of African-Americans to that of whites has reported mixed results. Some studies report African-Americans report lower levels of satisfaction with their health care than whites (Cooper-Patrick et al. 1999; LaVeist et al. 2000; Saha et al. 1999); others report higher levels of satisfaction among African-Americans (LaVeist et al. 2003); while others report both exhibited similar rates of satisfaction (Saha et al. 2003). These differences are due to the different independent variables and demographic factors that the studies observed. Saha et al. (2003) determined African-Americans were more satisfied with their care because they received on average more health services than patients of other races. These patients indicated their physicians treated them with immense respect, listened to them fully, and engaged them in decision-making.

The literature reports race-concordant visits are characterized by higher patient ratings of satisfaction and more positive judgments of physicians' participatory decision-making style (Cooper 2003 et al.; Cooper-Patrick 1999 et al.; Saha 1999 et al.) [10]. Cooper-Patrick et al.

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[10] These studies measured how much patients felt their physicians included them when making decisions regarding their health.

examined the role of gender concordance[11] and socioeconomic status on patient satisfaction and the physician-patient relationship. They determined that higher education levels resulted in more participatory visits. Physicians may be more likely to include patients with higher educational levels in decision-making more than patients with less education due to their deeper understanding of the biomedical causes of diseases. However, African-Americans had less participatory visits than whites, even when controlling for patient age, gender, education, marital status, health status and length of the physician-patient relationship. Gender concordance increased patient participation in the visit. Cooper-Patrick et al. concluded that both race concordance and gender concordance significantly increased patient satisfaction because physicians from other ethnic groups lack an understanding of patients' ethnic and cultural disease models or attributions of symptoms. Physicians may also not be aware of a patient's expectations, or have expectations of the visit that differ from their patients. Researchers suggest, "physicians and patients belonging to the same race or ethnic group are more likely to share cultural beliefs, values, and experiences in the society, allowing them to communicate more effectively and to feel more comfortable with one another" (Cooper-Patrick et al. 1999: 588).

One study examined the relationship between individual patient's beliefs about racism in the US health care system, specific racial/ethnic preferences for their physician, the race of their regular physician, and their satisfaction with that physician (Chen et al., 2005). Researchers determined there was a strong relationship between patient preference, racial concordance and patient satisfaction. African-Americans preferring same-race physicians who had an African-American physician were nearly three times more likely to rate their physician as "excellent" than African-Americans who had preferred a same-race physician but received care from a

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[11] Gender concordance is defined as the patient and physician being of the same gender.

physician outside their race. There were similar rates of satisfaction among participants without racial preferences for their physician, regardless of their physician race, indicating racial concordance may only impact patient satisfaction when a preference is not met. Patients that are not treated by physicians that match their preferences may suffer. Chen et al. speculated,

> Racial beliefs and preferences may affect the quality of their interaction with their physician, and may be a factor in racial disparities in health care. It is possible that patients with strong racial preferences who are in race-discordant relationships may trust their physicians less, be less likely to follow their physicians' recommendations, may not understand their physician, and may be less likely to develop an otherwise therapeutic relationship (2005:142).

Other studies have concretely linked physician preferences to health behaviors. For example, LaVeist et al. (2003) used three dimensions of health services utilization to predict health care utilization among minorities and whites based on physician-patient race concordance. Compared to patients whose regular doctors are of a different race, patients who are of the same racial or ethnic group as their physicians were more likely to use needed health services and less likely to postpone or delay seeking care. These patients also reported using a greater number of health services.

The Impact of Mistrust on Health Behaviors

Mistrust in one's physician and the health care system continues to impact satisfaction with care. Studies have indicated that overall, African-Americans report greater mistrust of their health care providers than whites (Casagrande et al. 2007; Collins, 2002; Halbert et al. 2006; LaVeist et al. 2000). As previously discussed, this mistrust likely stems from a history of racial discrimination, inhumane experimentation, exclusion from mainstream care, and unfair treatment. Halbert et al. (2006) examined the impact of social class, race and physician-concordance on trust. While neither sociodemographic factors nor race concordance were associated with low trust in health care providers among African-Americans, race was slightly proven to lower trust. Researchers determined 44.7% of African-Americans reported low trust in physicians, compared with 33.5% of whites. Additionally, greater medical mistrust decreases satisfaction with care (LaVeist et al. 2000). LaVeist et al. (2000) determined 51.4% of black patients agreed or strongly agreed with the statement, "Patients have sometimes been deceived or misled at hospitals" versus 42.4% of white patients. African-American patients were also nearly twice as likely as white patients to agree or strongly agree that, "Hospitals have sometimes done harmful experiments on patients without their knowledge". Patients who perceived more medical mistrust reported less satisfaction with their health care regardless of their race.

In addition, mistrust in one's physician and the health care system continues to impact health behaviors and beliefs. Lower satisfaction with care due to mistrust in one's provider has been shown to decrease willingness to seek care and follow treatment recommendations (Benkert et al. 2006; Casagrande et al. 2007). Distrust may also cause some persons to use alternative medicine, as greater respect for health care professionals was correlated with lower use of alternative medicine (Bargarzan et al. 2005). One study that observed perceptions of racism and mistrust of whites from the perspective of low-income African-Americans discovered both factors had a significant negative effect on trust and satisfaction with care (Benkert et al. 2006). Perceived discrimination had the greatest effect, impacting satisfaction both directly and indirectly through its direct negative impact on trust in provider. Although perceived racism and mistrust decrease satisfaction with care, within-group variation on this relationship has not been explored. Benkert et al. comment,

> The intersections of race, socioeconomic standing, age, cultural mistrust, perceptions of racism and trust in one's provider create a complex set of variables that could influence patient satisfaction. No studies testing a model of the relationships among perceived racism, cultural mistrust, trust and satisfaction within an African-American population, while controlling for contributing factors (gender, socioeconomic status and age) could be found despite a suspected empirical linkage among the constructs (2006:1533).

It is unknown if college-educated African-American women similarly distrust the healthcare system due to experiences of perceived racism.

Further research has classified two additional sub-categories of mistrust: overall trust in one’s regular primary care provider, and trust that the regular provider had no financial conflict of interest (O’Malley et al. 2004). O’Malley et al. (2004) explored factors that predict greater trust in primary care providers and examined the role of patient trust on utilization of preventative health services among low-income African-American women. His results determined less educated and older women had higher overall trust in their primary care providers; more educated and younger women had lower overall trust in their primary care providers. In addition, greater visit continuity with a specific provider and relationships that had been established for longer periods of time were both associated with higher levels of both dimensions of trust. Higher overall trust had a greater contribution to the usage of recommended preventative services than the physician-patient relationship alone. Patients were more likely to utilize preventative services if they trusted their physician than if they had seen the same provider for a long period of time. However, this study did not observe rates of perceived discrimination so it is unknown if greater trust in providers by older and less-educated women was due to lower perceptions of discrimination.

The Influence of Racial Discrimination on Health Behaviors

Preference for a same-race provider may stem from past experiences of racial discrimination from a healthcare provider. Malat and Hamilton (2006) assessed the extent to which preference for same-race healthcare providers among blacks is associated with perceptions of interpersonal racial discrimination in health care. Researchers speculated some African-Americans might prefer African-American physicians due to the belief that discrimination is frequent in racially discordant visits (Malat and Hamilton 2006; Malat and van Ryn 2005). However, the belief that racial discrimination can occur in healthcare visits regardless of physician race reduces the strength of these findings and the preference for a same-race provider. This represents a very complex association between discrimination and preference for same-race physician.

Physician preference studies provide key directions for future research. Chen et al. (2005) states, “One challenge for work in racial and ethnic health care disparities is determining which patients have strong beliefs about discrimination in health care” (142). It is not enough of a solution to increase the number of minority physicians and attempt to teach cultural competence; more effective options may be to address discrimination in the health care system and improve ways for patients to choose physicians (Chen et al. 2005). Although these recommendations stem from a study that surveyed middle-class African-Americans, this study did not examine the factors that led to beliefs of discrimination beyond race, excluding the impact of age and socioeconomic status. More research is needed to further specify how race and other factors, such as social class, affect the physician-patient relationship and influence patients’ perceptions of providers and discrimination (Malat and Hamilton 2006). In addition, more research needs to document the reasons African-Americans in higher socioeconomic classes also prefer African-American physicians beyond fear of discrimination from non-black health providers.

Reducing Health Disparities Through Medical Anthropology

More attention has been given to documenting examples of healthcare disparities than has been given to outlining concrete solutions to disparities. As lamented by Williams (2007), researchers have not developed easily accessible and well-proven interventions that are effective in eliminating disparities. Finding the underlying causes of disparities may be such a way to eliminate their prevalence. However, researchers disagree on how to document such factors and on which interventions to implement to reduce them. Particularly challenging, is the contrast between the biomedical and sociocultural views of the body and the impact of disease and illness. According to Womack, "in Western biomedicine, the body is viewed primarily as a physical object, one that may be subject to physically caused illness and can be treated according to scientifically tested procedures" (2010:12). In this model, everything that cannot be examined scientifically—the social, psychological, behavioral, cultural, political, and environmental—is excluded. This is detrimental because so much of the influences on health and disease come from these external factors. Anthropologists also criticize epidemiologists for their lack of impactful interventions. Public health interventions mainly exacerbate the gap between epidemiological theories and lay rationality, and place the blame on the individual for disease contraction (Walker 1998). Instead of this approach, medical anthropologists recommend the collection of more holistic data in order to design, implement, and evaluate medical interventions.

Anthropologists have proposed several models to account for health disparities between African-Americans and Caucasians. On the forefront of this research is William Dressler (1993), who criticized the following three models: racial genetic model; health behavior/lifestyle model; and socioeconomic status model. Instead, Dressler recommends a “social structure model”—a model “of ethnic health inequalities that takes into account the fact of continuing discrimination against people of color in color-conscious societies, a fact that automatically assigns people of color to a lower-ranked position in the social structure” (1993:336).

Anthropologists have also proposed models for the reduction of health disparities. However, researchers within medical anthropology remain divided about the most effective plan of action (biological/environment versus political/sociocultural). Walker best explains the differences in these theories:

> - The ecological approach observes health and disease in the context of human ecology by attempting to demonstrate the biological adaptability of various cultural traits that confer disease resistance. Based in epidemiology, it effectively determines the linkages between environment, host and pathogen, especially the impact of disease on mortality and fertility patterns. However, it excludes political and economic factors that impact disease contraction and progression.
> - The sociocultural approach expands the environmental approach to identify evolutionary and social factors that impact the body, but still excludes political factors. It uses a Western approach to medicine to assess constraining factors on health. Interventions from this standpoint focus on education, using Western beliefs of causation and prevention to alter behavior. This theory views disease as a failure to adapt to one's environment (1998:76-77).

However, as Armelagos et al. (1992) warn, disease contraction that is linked to environmental, genetic, or cultural factors, can lead persons to blame groups or individuals. Expanded further, this can lead to discrimination. They recommend an ethnomedical approach to medicine that integrates biological and cultural systems—a more inclusive approach that also considers economic and political factors. This model includes an examination of the historical factors that have impacted and continue to impact populations, communities, classes, and individuals. Such an approach would also observe the choices, behaviors, and strategies of persons with limited resources (Armelagos et al. 1992). To comprehend health care utilization patterns and design effective interventions requires understanding the impact of cultural practices and beliefs (Bailey 1987; Walker 1998). This analysis is crucial because it can illuminate whether an individual will utilize or reject available health services (Bailey 1987). Awareness of cultural factors may allow more personalized health education and intervention programs for minorities. Bailey recommends that educators,

> Know what the people are thinking; have a broad definition of health and an understanding of the breadth of those factors that have an impact on health; and realize the everlasting effects of discrimination. Once educators address these issues in the black community, perhaps the more basic problems of availability, accessibility, accountability, and acceptability of the health care system will be resolved (Bailey 1987:392).

The issue is that most researchers have not identified the range of health behaviors and beliefs in diverse US subpopulations from such a standpoint—most models ignore the impact of racial discrimination. Walker (1998) also argues that medical anthropology can make a **critical** difference in offering holistic perspectives of subcultures, especially due to its greatest asset—“inherent humanity”. The theoretical foundations of critical medical anthropology can provide comprehensive support and enlightenment to intervention programming, due to its focus on “political economy, the social relations of health and disease, and commitment to social action” (1998:84). Approaches must not be limited to biomedical factors and perceptions of disease, but must also examine social and cultural factors through a broad-focus and flexible methodology.

This research investigates the generational health behaviors and perceptions of African-American women in order to identify the changing impact of social class and culture on the health practices of this population. Medical anthropology has explored the changes in conceptions of disease from a sociocultural standpoint. Singer highlights alternative conceptions of disease can change, “As these systems change, the ways people—both healers and sufferers, as well as the larger community—think about health and illnesses change, and, as a result, the ways they respond to sickness change as well” (2003:424). It is important to not only document changes in the way disease and illness are perceived, but also changes in the way individuals and communities respond to them. Medical anthropology may also be in a unique position to identify these changes, as folk models of illness and use of alternative medicine in African-American communities are not always mentioned to physicians (Bailey 1988).

The factors that impact the health behaviors and beliefs of African-Americans are very complex. Not only are these factors confined to issues of social status and culture, but they also encompass issues of racial discrimination. Further research must consider economic, racial, and cultural elements in the examination of health behaviors, beliefs, and attitudes. Each of these entities have influenced reliance on biomedical care and folk practices. Racial discrimination has perpetuated unequal treatment from providers. In fact, African-American participants in one study described their providers as: “uncaring”, “disengaged”, “passive”, and unwilling to provide information or help (Grady and Edgar 2003). Cultural perceptions have propelled medical mistrust and reliance on self-treatment and folk medicine. Both factors have decreased satisfaction with care and increased preference for same-race physician. Although studies have considered the impact of race and culture on health behaviors and attitudes, they have often ignored the impact of social class beyond controlling access to care. This work provides insight into the impact of social class, race, and culture on the health practices and perceptions of college-educated African-American women through a broad focus and flexible methodology.

Chapter 3: Methodology

The goals of this study were to:

- Identify the health attitudes, beliefs, and behaviors of college-educated African-American women
- Determine how these health practices vary across generations
- Outline the impact of social class, culture, and race on the health behaviors, beliefs, and attitudes of this population
- Determine the physician preferences of this population

Study Population

The study population consisted of 106 members of a predominantly African-American sorority. The sorority has chapters on undergraduate campuses (known as collegiate chapters) and in local communities that contain college graduates (known as alumnae chapters). Participants were recruited from both a collegiate chapter and an alumnae chapter. The sorority was the best population to recruit women from different ages, as members range from ages 20-85 and distinction is given to members over sixty-five years of age. This recruitment method also ensured all participants had taken at least twenty-four credit hours at a college/university, because it is a requirement for sorority membership. All study participants currently reside in metro-Atlanta—a city often hailed as the “Black Mecca” due to the large number of successful blacks in the city.

Although a college education does not secure middle-class status or economic stability for African-Americans (Williams and Collins 1995), this research project will primarily view college-educated African-Americans in a different social class from African-Americans with a high school education or less. This classification will be used in lieu of income or poverty data. This justification comes from LaVeist who articulates,

> As a measure of socioeconomic status, educational attainment overcomes many of the shortcomings of income and poverty data... Educational attainment does have some nontrivial limitations; for one thing, educational attainment does not always do the best job of producing a hierarchy. A college graduate can be a bank teller or the bank president; a high school graduate can work as the janitor at Microsoft or he can also be Microsoft's founder. But in general education serves as a good measure for some aspects of socioeconomic status. Persons with higher levels of education generally enjoy a lifestyle that is more conducive to good health than the lifestyles of persons with less education. Most people complete their formal education by age twenty-five, so educational attainment is relatively stable in adulthood. Also, unlike income occupation or poverty, education does not fluctuate from year to year and does not decline as a person's health declines (2005:165).

Although there will be a few women in the study population who undoubtedly experience greater affluence than others, as a whole this population is predicted to experience more privileged lifestyles than African-American women in lower social classes. Greater prosperity has been shown to provide healthier lifestyles. As detailed by Mechanic,

> When new opportunities for improving health arise involving new knowledge or new technologies and requiring an individual response, those with better resources, knowledge, influence, and social networks are those who benefit most quickly. Thus, most new opportunities to promote population health inevitably favor the most advantaged (2005:337).

It is predicted that college-educated African-American women will have greater access to the healthcare system and report higher frequency of health insurance coverage and access to regular provider than less education African-American women. These advantages offer crucial opportunities to benefit from new knowledge and new technologies. Research will determine how this population utilizes new knowledge and technology to have healthier lifestyles.

Study Design

In order to ascertain the generational health behaviors of college-educated African-American women and document explanations for these behaviors, I utilized a two-part methodology: survey and focus group data. I selected focus groups to offer a wider breadth of responses, perspectives, and interaction between participants, and to decrease the effect of the interviewer on participants. Focus group questions were designed around the following themes: racial discrimination, health care, health behaviors, health outcomes, and physician preferences.

Surveys were distributed to obtain more general information from study participants about their health behaviors. Survey questions were designed using several different methods. Since one of the objectives of this study is to examine the intersection of race, social class, and health, some questions were adopted from previously conducted cross-sectional studies to allow data comparison with populations that this study had not examined. Ten questions were taken from the 2010 Behavioral Risk Factor Surveillance System Questionnaire. These questions ascertained the following demographic information: self-rated health status, insurance coverage, financial barriers to care, access to a regular healthcare provider, length of time since last healthcare visit, and perceived quality of health care given to different racial groups. From Casagrande et al. (2007), one question was added about reactions to racial discrimination from a healthcare provider while seeking care. From LaVeist et al. (2000), one question was added that asked participants to rate how much they agreed with the following statements:

1. “Patients have sometimes been deceived or misled at hospitals”,
2. “Hospitals often want to know more about your personal affairs or business than they really need to know”
3. “Hospitals have sometimes done harmful experiments on patients without their

knowledge”

4. “Rich patients receive better care at hospitals than poor patients do”
5. “Male patients receive better care at hospitals than female patients do”

Statements four and five were modified to the following: “I would receive better care if I made more money”; and “I would receive better care if I were male”. From Blanchard and Lurie (2004), the following question, “Do you think there was ever a time when you would have gotten better medical care if you had belonged to a different race or ethnic group?”, was modified to ask participants to rate how strongly they agreed with the following statement, “I would receive better care if I were white”. Survey questions also used questions from Barzargan et al. (2005) that asked participants if they had used certain treatments to prevent sickness; to treat sickness; and to substitute for biomedical care. These questions were expanded to also survey physician preferences, generational differences in health behaviors, experiences of racial discrimination, and attitudes towards biomedical care.

The survey was created using an online account with Qualtrics Survey Software. Before the survey was distributed to participants, a pilot survey was conducted to offer feedback on length of time it took to complete the survey, readability of survey questions, and content of the survey. Consent for the survey was obtained on the first page of the online survey; participants checked a box indicating their consent before proceeding to the first question. The survey was password protected to ensure responses were from the target study population only. Survey responses were only visible to the researcher.

Data Collection

The Institutional Review Board of Emory University approved this study. The local alumnae chapter also approved this research project, the use of their community center to conduct focus groups, and recruitment of their chapter members. The survey was distributed to all members on the alumnae chapter listserv through the chapter president using a lay summary, protocol, and email template. Response to the survey was fairly rapid, with over fifty women taking the survey in the first week. Paper copies of the survey were completed at the February chapter meeting, which yielded nine more responses. In addition, the researcher emailed a separate link to the online survey to undergraduate sorority members. These methods resulted in 106 survey responses. Only one participant did not complete the survey, yielding a 99% completion rate.

A few difficulties were initially encountered in recruiting participants for focus groups. Participants aged 40-80 were recruited from the alumnae chapter. While providing sign-up sheets for evening focus groups at chapter meetings yielded six persons for the 40-59 age focus group, it did not generate any for the 60-80 age focus group. To solve this, the 60-80 age focus group was scheduled during the day for retirees who do not usually travel at night. A participant in the 40-59 age focus group contacted members to schedule the 60-80 age focus group; she recruited four participants for discussion. Only sorority sisters from the undergraduate chapter were included in the 20-39 age focus group, thus the actual age range for the youngest focus group is 20-22. Six members were randomly selected to participate in the 20-22 age focus group. From these six, four were able to attend the focus group discussion.

Three focus groups were conducted with a total of fourteen college-educated African-American women; four between the ages of 20-22, six between the ages of 40-59, and four between the ages of 60-80. The focus groups with current college students were conducted at Emory University. The focus groups with college graduates were conducted at a local community center. Written consent was obtained before the start of the group discussion. All focus groups were moderated, audio-recorded, and transcribed by the researcher in a format outlined by Kreuger (1998). Monetary compensation was not provided to participants, however, they were informed that their participation would contribute to existing literature on the health behaviors of African-Americans and possibly help improve health care for African-American women.

During the focus groups, participants were shown a two-minute clip from "Unnatural Causes: Is Inequality Making Us Sick?".[12] The clip highlights recent scientific findings that have shown middle and upper class African-American women still disproportionately suffer from poor health outcomes despite following physician recommendations for a healthy lifestyle. This research links the increase in the number of low-birth weight infants born to African-American women to racism encountered before and during pregnancy. The first question posed to participants asked them to evaluate the accuracy of this conclusion.

Participants in all three focus groups described their health behaviors and were willing to share personal stories about their experiences. The 40-59 age focus group generated by far the most active conversation (to the point where conversation addressed all key topics before questions on the given topics were posed to the group). Even though regional background was not considered when recruiting participants, focus group members were from different parts of the country. The atmosphere in the focus groups was quite informal, participants in the 40-60 age focus group even made a joke about me for not bringing food because I am a health nut.

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[12] This video clip is available at: http://www.unnaturalcauses.org/video_clips_detail.php?res_id=70.

Participants also addressed questions to each other to generate more in-depth responses. Commonalities between the study population and myself included being a member of the sorority and an African-American female—characteristics which helped encourage research participation and comfort with sharing information during focus groups.

For the most part, difficulties encountered in the 20-22 and 40-59 age focus groups were due to my inexperience as a moderator and will be discussed in the limitations of this study. A few difficulties encountered with the 60-80 age focus group were not caused by this. When the “Unnatural Causes” clip was played on my laptop for this group, the volume was not quite loud enough. As a result, I provided a summary of the content of the video before asking participants to evaluate the accuracy of the conclusions reached by researchers. In addition, some questions needed to be clarified and repeated to this focus group. The questions that had to be repeated focused on: the impact of past discrimination on future health care, healthcare advice from family and friends, and how to improve the health care of African-Americans. Despite this, all three groups addressed all areas of discussion that the researcher sought to cover.

Data Analysis

Immediately following the focus groups, field notes were written about the focus group discussion in Microsoft Word. Key themes of each discussion were outlined and times were recorded to reference when the focus group discussed each theme. Once these time markers were added, I relistened to the audiotapes and documented occurrences of relevant quotes. These quotes were later transcribed into a Microsoft Word document. Following each quote, code words were included to indicate content of discussion. This data was analyzed to generate explanations for the health attitudes, beliefs, and behaviors of college-educated African-

American women. This analysis also recorded commonalities and differences across generations and regional backgrounds.

Survey data was analyzed through the Qualtrics Survey Software once all responses were recorded. An initial report was generated summarizing responses to all questions. Cross tabulations were generated to display responses to each question by age group. Qualtrics automatically conducted chi-squared tests and reported p-values for each cross tabulation. Data was collapsed for questions that reported a chi-squared value greater than five due to empty cells. Quantitative data was then exported to Microsoft Excel and Microsoft Word for further analysis and reporting.

Limitations of This Study

Despite careful efforts during study design and data collection, there are still limitations of this study that need to be addressed. Some limitations are related to the methodology used to conduct focus groups. Firstly, I am not a skilled moderator. This did not seem to affect the group discussion during the 20-22 or 40-59 age groups, but caused difficulty during the 60-80 age focus groups when participants did not provide supporting information for their statements. I was unsure how to probe participants for further information and may have limited their responses by providing examples of answers to the questions posed. Secondly, there may have been bias in participant selection for the 41-60 and 60-80 age focus groups since participants were not selected randomly. Thirdly, only one focus group per each generation was carried out due to time constraints. There was one limitation with the survey: it was only distributed to active members of the Alumnae chapter who are on the mailing list. Those who were not on the mailing list nor in attendance at the February chapter meeting were not invited to participate.

Study participants are also not representative of all college-educated African-American women in the US, nor of all college-educated women in Atlanta. As such, our results may not generalize to other groups of college-educated African-American women. Future research should include participants from additional alumnae and undergraduate chapters and utilize qualitative and quantitative methods to validate and extend study findings. Additional research must also determine treatments used for specific illnesses. Participants in this study reported the types of care they utilized for their “last sickness episode”. Due to the wide age range of this study population, last perceived illness is likely different, causing differences in the type of care utilized. It should be verified if the same health behaviors are used to treat all forms of sickness, i.e., if participants treat a minor sickness (e.g. the common cold) the same way as they do a chronic illness (e.g. hypertension).

Chapter 4: Culture and the Health Behaviors, Attitudes, and Beliefs of African-American Women

Data collection methods yielded quantitative data from 106 survey responses and qualitative data from three focus groups. Data from both methodologies will be presented in this chapter to provide both group and individual perceptions of the health behaviors, attitudes, and beliefs of college-educated African-American women. Demographic data from the 2009 Behavioral Risk Factor Surveillance Survey (BRFSS) will also be cited to contextualize the significance of these findings. Study results have provided deeper insight into the health behaviors of college-educated African-American women centered around: self-treatment, delayed seeking of professional care, balancing of traditional and biomedical care, and researching of treatment options.

Demographics of the Study Population

Findings from the quantitative component of this study are presented in Table 1. All age groups were adequately represented; 40% of participants were between the ages of 20-39, 27% were between the ages of 40-59, and 33% were between the ages of 60-80. Most participants reported being in fairly good health; 68% of respondents reported a health status of either excellent or very good. In contrast, only 5% of respondents reported they were in fair health and 0% reported being in poor health. There were also very low rates of unemployment among this population. While 33 persons reported they were currently not employed outside their home, 19 were retired and 5 were undergraduate students (4 undergraduate students hold jobs on campus), leaving only 9 persons out of 106 who were either unemployed or self-employed[13]. A very low percentage of respondents (7%) reported they are healthcare employees. In addition, most participants (78%) reported a total annual household income of greater than $50,000/year. This data indicates that college-educated women have attained relative financial stability and economic success, supporting the prediction that college-educated African-American women enjoy more affluent lifestyles than women with less education.

Table 1: Participant Demographics

Characteristics	Study Population	Percentage
Age		
20-39	42	40%
40-59	29	27%
60-80	35	33%
Total Number of Responses	106	100%
Health Status		
Excellent	16	15%
Very Good	56	53%
Good	29	27%
Fair	5	5%
Poor	0	0%
Total Number of Responses	106	100%
Currently Employed Outside the Home?		
Yes	71	68%
No	33	32%
Total Number of Responses	104	100%
Currently Employed in Health Care Field?		
Yes	5	7%
No	66	93%
Total Number of Responses	71	100%
Total Annual Household Income		
$30,000 or Less	8	8%
$30,001-50,000	15	14%
$50,001-75,000	30	29%
$75,001-100,000	26	25%
$100,001-200,000	22	21%

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[13] Survey questions on employment status did not differentiate between persons who were unemployed or self-employed.

$200,001-500,000	3	3%
$500,001 or Greater	0	0%
Total Number of Responses	104	100%

Treatment During Times of Sickness: Self-Care and Alternative Medicine Usage

This research employed several questions to obtain information about the illness behaviors of college-educated African-Americans. One question asked survey participants to select all of the treatments they used the last time they were sick. Study responses are detailed in **Table 2**.

Table 2: Treatment Utilized During Most Recent Sickness Episode

Treatment Methods (N=104)	Affirmative Response	% Yes
Visited general practitioner for care	64	62%
Treated yourself (home remedies, over-the-counter medicine, self-diagnosis, etc.)	61	59%
Pray, Read the Bible	20	19%
Asked a friend, family member in the healthcare profession for advice	18	17%
Asked a friend, family member outside the healthcare profession for advice	13	13%
Visited the emergency room for care	4	4%
Did nothing, waited for symptoms to stop	2	2%

Although the largest number of participants sought medical treatment from a primary care physician (62%), a very close percentage of participants treated themselves (59%). Because it was expected that a vast majority of participants would seek advice from friends/family about their condition, it was unexpected that prayer/reading the Bible would be the third most utilized treatment. Very few participants (2%) did nothing and waited for their symptoms to stop, which indicates that some care is sought for all episodes of sickness among college-educated African-American women.

As the above question only ascertained treatments utilized during the most recent episode of sickness, the following survey question asked about all treatments used in the past to prevent or treat sickness. These results are presented in **Table 3**.

Table 3: Utilization of Alternative Medicine Outside of Biomedical Care to Treat or Prevent Sickness

Treatment Method	Yes	No	Not Sure/Can't Remember	% Yes	Total Responses
Over-the-counter medicine	104	1	0	99%	103
Traditional, or home remedies	94	9	1	90%	104
Advice from friend/family member in healthcare field	72	24	1	74%	97
Prayer, Read the Bible	70	30	1	69%	101
Herbal remedies, Vitamin therapy	69	30	3	68%	102
Advice from friend/family member outside healthcare field	56	30	3	63%	89
Consulting a religious leader (pastor, priest, etc.)	8	82	2	9%	92
Consulting a psychic	7	83	1	8%	91
Consulting a non-church-based spiritual healer (cuarderno, voodoo, mystic, shaman)	1	89	1	1%	91

The table indicates that almost all participants have used over-the-counter medicine, traditional/home remedies, advice from family/friends, prayer/reading the Bible, and herbal remedies/vitamin therapy to treat or prevent sickness. It was not surprising that only one person had consulted a non-church-based spiritual healer, as their usage has been infrequently documented in the health literature on African-American populations during the past ten years.

Participants were lastly asked, “Have you ever used any of the following to substitute for conventional medical care?”. These results are summarized in Table 4. These results were very similar to those presented in Table 3 on treatments to prevent or treat sickness. The only differences were that herbal remedies and vitamin therapy were used more frequently than prayer/reading the Bible. Although 18% more participants reported utilizing religious treatments to treat/prevent sickness than they reported utilizing religious treatments as a substitute for medical care, these treatments were still used by nearly 50% of study participants for the latter purpose. This indicates that religion plays a large role in the health behaviors and beliefs of African-Americans.

Table 4: Utilization of Alternative Medicine to Substitute for Biomedical Care

Treatment Method	Yes	No	Not Sure/Can’t Remember	% Yes	Total Responses
Over-the-counter medicine	87	17	0	84%	104
Traditional, or home remedies	75	25	2	74%	102
Advice from friend/family member in healthcare field	53	44	1	54%	98
Prayer, Read the Bible	51	48	2	51%	101
Herbal remedies, Vitamin therapy	45	55	1	45%	101
Advice from friend/family member outside healthcare field	41	49	2	45%	92
Consulting a religious leader (pastor, priest, etc.)	5	87	1	5%	93
Consulting a psychic	2	90	2	2%	94
Consulting a non-church-based spiritual healer (cuarderno, voodoo, mystic, shaman)	1	91	2	1%	94

The only explanations for the use of religious treatments as a form of alternative medicine emerged from the 20-22 age focus group. During this focus group, religion and health care were discussed in the context of factors that impact health care utilization. One participant talked about putting faith in God over modern medicine,

> A lot of times you feel like it's a lack of faith if you run to the doctor for everything. It's in many gospel songs: 'The doctor said one thing, Jesus said another!'…So you think, 'I can pray on it'. And I'm not gonna say it hasn't worked; I feel like it has to some extent. But it's kind of like when do we draw the line? It's just cultural and just how we're raised…If something hurts, you pray about it and it will stop… and if it keeps coming back then maybe you go to the doctor. But pray first, before you do anything else (Participant from the 20-22 age focus group).

This sentiment is key to understanding the large percentage of participants who have used religious treatments as a form of alternative medicine; it is "cultural"—a practice that has been passed on from generation to generation. Often, African-American women pray before seeking care and then only seek additional treatments if the condition seems to continue for a prolonged period of time or if it worsens. Another participant offers an explanation for using religion as a substitute for conventional medical care, especially care in which a physician has disrespected a patient,

> Someone who has been discriminated against might be even hesitant to take the [recommended] medicine, even if they know what's wrong with them and they've been treated…it's kind of like [what the previous participant] said with the faith and gospel songs and God…they have a better feeling about praying to God about things… [they believe] 'I could pray to God and have faith and get better or I could take this medicine that this mean doctor gave me.' … They might admit that it's good to take the medicine or they might not … find it as important to do it on a regular basis like they should (Participant from the 20-22 age focus group).

All other focus group participants were in agreement with this comment, which indicates religion is frequently used as a substitute for biomedical care among this population. This is not to say that the participant suggests relying on religion for health care is more effective than seeking biomedical care. She states patients should follow physician recommendations, but African-Americans turn to religion instead of biomedicine when mainstream medical care has not been effective or positive. This comment describes African-Americans may be less likely to follow physician recommendations after disrespectful treatment from a physician; such dissatisfaction with care may cause African-Americans to stop seeking biomedical care.

Regional Differences in Health Behaviors

Focus group discussion identified possible regional differences in the health behaviors of college-educated African-American women. Women raised in the South were less likely to have seen physicians growing up. In contrast, one participant from a northern state indicated that she has always had adequate access to health care. The latter case is described by a focus group participant,

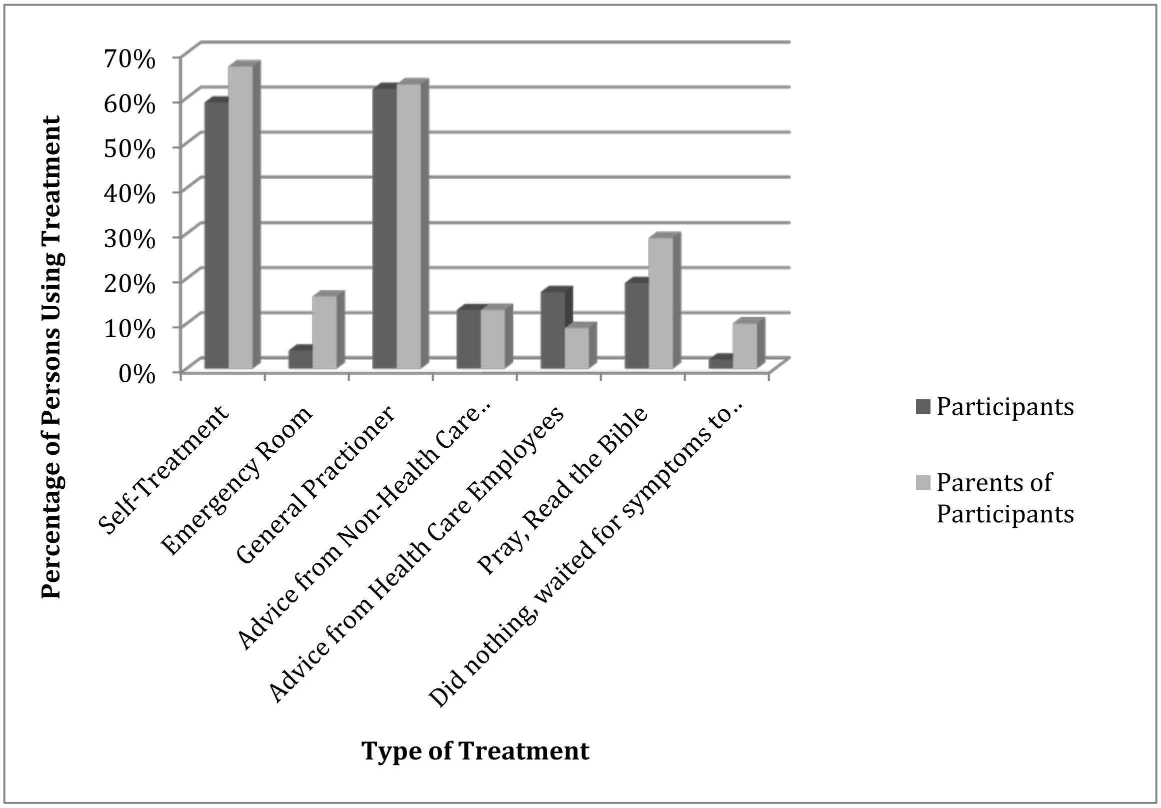
> Well, I'm not from the South. I'm from the big city of Chicago so I see things just a little differently…But when I grew up, we had black physicians. We had black dentists so I have gone to black doctors throughout my life … My parents went to the doctor religiously so it wasn't like, 'Okay I'm sick and I'm gonna take care of myself' [or] 'I'm gonna self-medicate'. They would go to the doctor (Participant from the 40-59 age focus group).

This comment is key because it highlights intragroup variation. From the participant's perspective, African-Americans who grew up in the North had greater opportunities to rely on conventional medical care, causing them to rely less on self-treatment for sickness. During centuries of oppression and poverty, African-Americans were frequently isolated from even basic care and subsequently developed their own forms of treatment using easily accessible herbs and other ingredients (Barnett et al. 2003). This perpetuated self-treatment and use of alternative and folk medicine. With increased access to medical care over time, however, African-American women began using conventional medical care with higher frequency.

Generational Differences in Utilization of Health Care Treatments

Analysis of survey data yielded generational differences in the treatment patterns of college-educated African-Americans. Responses to “The last time you were sick, what did you do? (Check all that apply)” and “When your parents felt sick, what did they do? (Check all that apply)” are combined in Chart 1.

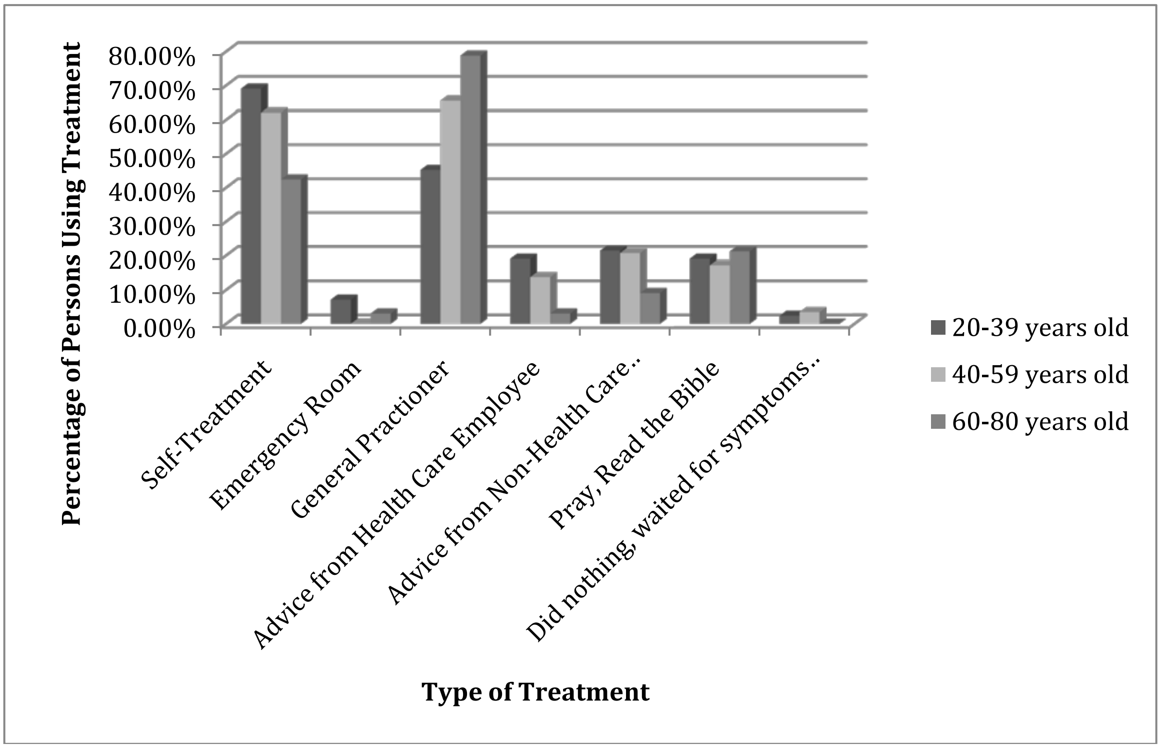
Chart 1: Health Treatment Utilized During Episodes of Sickness by Participants Versus Their Parents



This chart mainly displays only slight differences in the types of treatments that were most frequently used by each generation. There was only a 1% difference in the frequencies of seeking care from a general practitioner (62% of participants versus 63% of their parents used this treatment) and a 3% difference in self-treatment (59% of participants versus 67% of their parents used this treatment). Prayer was again the third most common treatment for both populations. Neither subgroup relied heavily on care from the emergency room or advice from friends/family, nor did either population simply wait for symptoms to abate. However, 16% of participants reported their parents had utilized the emergency room for care while only 4% of participants indicated they had visited the emergency department for treatment. As studies have documented African-Americans seek care from the emergency department when they cannot afford to see a primary care physician (Neighbors 1986), this may suggest the parents of participants experienced greater financial barriers to care than study participants. In addition, participants were more likely to report their parents either did not utilize any remedy or prayed/read the Bible than they were to use these treatments themselves. However, the difference in utilization rates between the two subgroups was no greater than 10% in either case.

Analysis identified treatment patterns for each age group in the study. Chart 2 presents responses to every type of treatment utilized during last sickness episode by each age group. This analysis produced more pronounced differences across generations. Persons aged 20-39 were most likely to indicate they had treated themselves the last time they were sick. While 69% of persons in this age group utilized self-treatment, only 45% visited a general practitioner for care. In contrast, both the 40-59 and 60-80 age groups were most likely to have sought care from a general practitioner the last time they were sick, with 66% and 79% of participants utilizing this treatment respectively. In addition, 62% of participants ages 40-59 utilized self-treatment while only 42% of participants ages 60-80 treated themselves the last time they were sick. For participants ages 40-59, asking a friend/family member employed in the health care field was the third most utilized factor. However, the third most frequently utilized factor for the oldest age group was prayer/read the Bible. The 20-39 age group utilized prayer/reading the Bible and seeking advice from someone employed in health care equally. While the youngest generation was somewhat more likely to visit the emergency room, percentages for this treatment did not vary tremendously across generations. All age groups were least likely to have done nothing until symptoms stopped.

Chart 2: Type of Treatment Utilized During Last Sickness Episode by Age Group



Analysis of focus group discussion indicated varying degrees of support for the benefits of using other forms of care outside of biomedicine. The slight variation in participants utilizing advice from others can be explained by how helpful participants perceive such advice can be. Some participants felt their health could be improved by advice from friends; others chose to ignore the advice and follow practices they felt would be more effective. One participant explained how the content of advice from friends/family can vary,

> If you're getting advice from friends, from like other college-educated black women, that's on a different… level, to some extent [from advice from others]. They're more inclined to maybe trust their physician or they might have some previous knowledge... So I feel like that might actually be more beneficial, depending on the situation for the most part." (Participant from the 20-22 age focus group).

This woman argues that advice from certain persons is more credible than advice from others. College-educated women are presumed to offer better advice because of more experiences and interactions with biomedical care, and greater trust in their physicians. She believes that their advice is more beneficial ("on a different level") than that of persons with a lower educational level, who would presumably rely less on previous biomedical knowledge ("previous knowledge") and more on traditional beliefs. The participant also states there is less trust in physicians among African-Americans with a high school education or less.

Efficacy of Home Remedies

Although the 20-39 age group was far more likely to utilize self-treatment over care from a general practitioner (see Table 2)[14], this does not imply a heavy reliance on folk treatments. This age group mainly reported utilizing over-the-counter medication and biomedical knowledge to treat themselves. One participant commented on the home remedies her father uses,

> With … stuff like the common cold, or anything like [that] they have old remedies for [them]. It's like, 'You don't need to go to the doctor...Let me… just get you a little honey, and… a little brandy or something and mix it together.' [Another participant has a strong reaction of surprise] No, that's what they do… that's what my dad did… they use old remedies. They really don't see the need to go to the doctor for … common stuff like any type of common cold, or open sore, or anything. They just … have their own type of medicine that they can just put together … like, '[Here,] you can take this.' And I mean, it works sometimes… if you have a sore throat [they'll say], 'Oh yeah, gargle like this,' and 'This will help', and stuff (Participant from the 20-22 age group).

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[14] This may also be a function of youth and the ability to recover more quickly with less intervention.

The home remedies of African-Americans are quite diverse and are used to treat different types of sickness. In describing the home remedies her father uses for illness, the participant never once mentioned that she uses them too, stating “that’s what they do”, not “that’s what *we* do”. Another participant had a strong reaction of surprise to these comments, implying that such health behaviors are not familiar to all college-educated African-Americans. It is also important to note that home remedies were utilized by the participant’s parents to substitute for conventional medical care (“you don’t need to go to the doctor…you can take this”).

Participants were then asked about the efficacy of home remedies. The following comment documents their continued use by this population, although only to treat sickness and not to prevent it,

> I agree about the [efficacy of] old remedies. Definitely. [But only] when I would get sick. [There are] certain things you’re supposed to do every day. [For example], my grandmother would eat a spoonful of vinegar every day, and I forget why, but she would just do that and she would mix honey and stuff, and just random stuff that’s supposed to prevent all these other kinds of things. She’s like, ‘You should do this too.’ And I’m like, ‘Actually no, I’ll just wait until I get sick. If I get sick I’ll take some medicine.’ But I think those are some differences [between my generation and those of the past]” (Participant from 20-22 age group).

All participants in the 20-39 age focus group believe in the efficacy of home remedies. However, their usage was too infrequent for participants to recall the symptoms they help alleviate and the illnesses they help prevent, as the participant could not remember why her grandmother would ingest a spoonful of vinegar daily. For these women, home remedies are used to treat sickness instead of preventing it. This may suggest that with greater access to care, less folk practices are passed down to subsequent generations.

Because the survey did not ask for examples of home remedies or about specific therapies for sickness, focus group participants were asked to give examples of therapies they had been given by family members in the past. The participant quoted above also mentioned that her grandmother would give her vinegar to treat a hand cramp, which the participant believed was effective. In addition, focus group participants stated that the substances used for treatment remain the same; new elements are rarely utilized. One participant explained,

> If anything, I might see that [African-Americans] try to apply [a given therapy] to more things. There's one remedy and it's usually [for] if you're sick. But if your stomach hurts too, you're not really sick. [But others encourage you], 'Well, try that same remedy. You don't know. [It might work].' It's more like you try to expand it [versus creating and trying a new therapy] (Participant from the 20-39 age focus group).

Although 20% of this population utilized advice from family/friends who did not work in health care the last time they were sick, the above comments suggest advice given by parents or grandparents is not always followed, and home remedies for treatment are not always taken. This is also supported by the following comment about seeking diagnosis from a physician,

> The moment I tell [my mom] I don't fell well, she always wants me to go to the doctor. And I never do. Because I'm the one that says, 'No. It's not that bad.'… I'm just not that inclined to go to the doctor mostly because I feel like it's a hassle. So I'm … just like, 'Oh, it's not that bad'. I'll just…take everything that I can buy because I'm like, 'They're supposed to work…They're for sale.' But…my mom's just one of those people. She'll say, 'Go to the doctor,' you know, 'Let them look at you. Let them check you out.' And I'm like, 'No. My nose is just stuffed. It's not that bad' (Participant from the 20-22 age focus group).

This sentiment could explain the generational differences in the treatment patterns highlighted in Chart 2. Younger generations may be more likely to treat themselves and utilize over-the-counter medication than see a general practitioner for less serious health problems that do not require professional medical care. While younger generations mainly used self-treatment, older generations used self-treatment in conjunction with seeing a physician, indicating home remedies are still being used among older generations of college-educated African-American women to prevent and treat illness more than younger generations.

"You Must Do Your Research"

All three focus groups highlighted the importance of using research to obtain further information about illnesses. One participant commented, "You're willing to do your own research so you're more likely to get a proper diagnosis" (20-22 age participant). This explains the greater reliance on self-treatment within younger generations. Participants may not seek professional medical care because they believe it is a "hassle" to seek care from a physician. Another reason self-treatment is so frequently used is due to the availability of biomedical knowledge. One participant detailed, "I just found that there's so much information now about all of these illnesses…You see it on tv all of the time. You read about it… There's a lot of information… As college-educated women we make better decisions now. I think that's what I'm trying to say" (Participant from 40-59 age group). College-educated African-American women feel they make better decisions because of easily-accessible biomedical information. Younger generations are more likely to utilize this information to make accurate diagnoses than older generations due to a greater access to information on the internet and coverage of this material in school. This may also explain why older generations continue to seek health care from physicians. While it may seem that older generations of college-educated African-American women do not research their conditions as much as younger generations, this is often not the case. One participant responds to the consequences of not following physician advice,

> I think … from one perspective [not following physician advice] can be called for. I think sometimes you intentionally don't follow the advice... And if you've done research to say that there's another direction you can go in then you hopefully will be okay…I don't think ignoring it is good, but I think doing something with it is good, even if you don't follow what the doctor said…My experience with that relates to hormone treatments during the time of menopause and I had had the same physician whom I now have. We fought … for about [the first] 10 years [I was going through] menopause… I didn't stop going to her but she wanted me to do whatever the treatment at the time was and I told her I was not going to do

> that…But I didn't do it and I said, 'I'm going to do some research, you do some research.' I went to my GP; we all researched together; we found different kinds of home remedies out there... And the research proved me correct…So it wasn't like I ignored what she said, because I kept going to her… But I did my research. And even when I came up not sure of what I was gonna do, I was sure of what I wasn't gonna do. I wasn't gonna do what was being prescribed at that time because I thought there hadn't been enough research [in support of the treatment]. That's why I didn't do it (Participant from the 60-80 age focus group).

This comment implies college-educated African-American women use their higher educational attainment to take greater control of their health care. Physician advice is not completely followed if sufficient research does not support its efficacy and safety. Thus, not following physician recommendations can actually be good for one's health. In this case, the participant decreased her risk for breast cancer by researching hormone therapy and determining it would not be a good therapy for her to undergo. In addition, these concerns were vocalized with her physician, even though they contrasted what the physician wanted for her. This participant further details this has been a recent change in the health behaviors of African-American women,

> My mother is not having the best of health outcomes... I'm not completely sure she followed the doctor's directions, you know. She wouldn't have…And … if I can speak for this group, I'm not sure if any of our mothers, or aunts, or even myself let's say, would completely follow a doctor's instructions. With myself it's because there's so much to read through and puzzle through and so many life experiences to go on that I'm probably never gonna follow one doctor's suggestion completely. I'm going to bring into the picture a lot my own thoughts and ideas and try to meld those with the doctor's thoughts and ideas. But it would have to be a very critical situation for me to completely accept what the doctor says if I have some other thoughts about it (Participant from the 60-80 age focus group).

This participant believes that African-Americans in the past did not completely follow doctor's recommendations—presumably due to medical mistrust. As implied in this remark, contemporary college-educated African-American women do not completely follow physician advice because they utilize biomedical information to ensure an appropriate treatment plan. This increases patient involvement during the physician visit and may improve health outcomes by ensuring the best treatment options are recommended for each individual. In contrast, participants in the 40-59 age focus group stated their grandparents followed physician advice without question, even if the doctor was a “quack”, because what the doctor said was “law”.

A Healthy Balance Is Key; “Too Much of Anything Is Bad”

Focus group participants indicated there should be a balance between traditional and conventional medicine in the treatment of sickness for all. One participant commented,

> I would also [support] finding a healthy balance between the remedies of the past and the medications of the present just because I’m not going to say that doctors don’t, to some extent … overmedicate… I’m pretty sure there’s a pill or some drug you can take for everything that you can also just cure with vinegar or something… So just [make] sure that you do what you can do just naturally and holistically…[Avoid] just leaning on any one [method] too much because too much of anything is bad (Participant from 20-22 age focus group).

This comment represents a belief that doctors overmedicate their patients without supporting more natural or holistic treatments. Relying too much on biomedicine or folk medicine can have negative consequences on the health of college-educated African-American women (“too much of anything is bad”). This may explain why all three generations in this study utilized both biomedical care and alternative medicine heavily. This was further supported by another participant,

> There has to be balance. For me, if I get ill I’m first going to try to do something holistic, or do something natural. Thank God, I haven’t been [seriously] ill…I might get a cold. I had a cold last week so I did vitamin C; I did orange juice. I didn’t do any over-the-counter stuff and it was gone in less than a week. I still exercise[d] and all that so it was gone in less than a week. [But] you have to go to the doctor [too]. I have health insurance so I’m going to use it but if I’ve got something’s that minor [that] doesn’t persist [I’m going to self-medicate]. If I [encounter a larger problem], I’m gonna get checked out. When I get that [prescribed] medication, I’m going home and going online to see … what [it is

> all] about. What are the side effects? [I'll] ask the doctor [before I leave] and if [the recommended therapy] bothers me, I'm going back... Because my question always is, once I'm diagnosed if there's something wrong, 'Is there something natural that I can do?' Be it diet; be it exercise; be it something else. 'Can I do that first?' If not, then I'll take some kind of med[ication]s, but I prefer, if at all possible, to do something natural[15] (Participant from the 40-59 age focus group).

This participant stated that she would rather use natural therapies and vitamins than over-the-counter medications to shorten sickness time and decrease reliance on a physician for a small health problem. However, she would still utilize health care if necessary. Once a prescription was given, she would research it to make sure it was the best treatment for her, but her first choice would be to do something "natural". This differs from the health behaviors reported by participants ages 20-22, who focused more on over-the-counter medicine than natural remedies. However, because this study did not ask participants to identify their ethnic backgrounds, these health behaviors may not be reflective of all African-Americans as they represent descendents of black women from various regions (i.e.: Africa, Caribbean, etc.).

Delays in Seeking Biomedical Care

The two youngest groups described waiting to seek care until they felt the illness was actually serious enough to see a physician. One participant in the 20-22 age focus groups described, "You'll wait and wait and [the attitude is], 'Oh, well something hurts but it's not really stopping me from going about my daily routine.' It's not until it [hinders you] from doing your daily routine that you decide, 'Okay. Now I need to go to the doctor' ". This helps explain Chart 2. Younger generations may be less likely to seek care when the illness does not impact their daily activities, especially since they feel seeing a physician is a "hassle".

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[15] This comment cannot be generalized to all college-educated women as the participant is of Caribbean descent.

There is also a delay in adopting preventative therapies recommended by physicians within the African-American community. As detailed by another participant,

> I see it week after week. I lead Weight Watchers meetings so I see people every week who …[are] coming in because their doctor said this is a healthy way to do it and if [they] don't do something now, [they] will [suffer]… All of a sudden it's, 'Oh, I really gotta do something otherwise I'm gonna be in … danger'. The other thing is…if you know someone else in your family is on blood pressure medicine or is diabetic and has to take insulin and you see all of that, you go, 'I don't know if that's what I want to do.' So when someone tells you 'Well if you don't make changes, that's well you're gonna be', I think people start going, 'Oh well wait a minute, let me figure out what those changes are'. It's [also] being willing to make them. Sometimes people [know and understand them but] don't wanna make the change" (Participant from the 40-69 age focus group).

Essentially, changes are not made until the life of the person is threatened—until a person is in "danger". Seeing family members struggle with their illnesses also encourages a person to follow biomedical health recommendations to decrease the risk of encountering the same poor health outcomes. What emerges from this comment is that many African-Americans are not willing to make the changes to healthier lifestyles, even though they understand the changes they need to make. Part of the reason these changes are not made is because health behaviors are cultural experiences learned from their elders. This is especially the case with diet[16].

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[16] See Appendix for greater detail on cultural factors that have influenced the diets of African-American women.

Chapter 5: Factors Impacting the Health Behaviors of African-American Women

Outlining the health attitudes, beliefs, and behaviors of college-educated African-American women was only one goal of this study. Another goal was to examine the factors that influenced these behaviors and perceptions. This chapter will present the economic, cultural, and societal factors that have shaped the health practices and attitudes of college-educated African-American women. While study results imply racial discrimination and medical mistrust have not had a significant impact on the health behaviors of participants, social class and physician characteristics have been critical influences. Despite a college education, quantitative and qualitative data suggest African-American women continue to face financial and cultural barriers to care. The chapter concludes with suggestions from participants on how their health care can be improved.

The Subtle Impact of Racial Discrimination

Participants were asked a series of four questions about their past experiences with discrimination. The results are reported in Table 5. While 70% of participants reported encountering racial discrimination at some time in their past, only 13% had experienced racial discrimination in the past six months.

Table 5: Reported Past Experiences of Racial Discrimination

Type of Racial Discrimination	Study Population	Percentage
Discrimination in Any Setting		
Yes	73	70%
No	31	30%
Total Responses	104	100%
Discrimination in Any Setting in Past 6		

Months		
Yes	14	13%
No	91	87%
Total Responses	105	100%
Discrimination from Healthcare Provider		
Yes	16	15%
No	88	85%
Total Responses	104	100%
Discrimination from Healthcare Provider in Past 12 Months		
Yes	3	3%
No	100	95%
Can’t Remember/Unsure	2	2%
Total Responses	105	100%

Overall, reported rates of discrimination from a healthcare provider were very low. Only 15% of respondents reported experiencing discrimination from a healthcare provider at some point in their past; only three women indicated this discrimination occurred within the past six months. All three persons stated this would not impact their willingness to seek health care, visit a physician, fill a prescription on time, follow doctor’s orders, return for a follow-up appointment, get a recommended test, etc. when needed in the future. Because there was such a small number of participants experiencing discrimination, it cannot be concluded from survey data alone that college-educated African-American women still continue to seek conventional medical care despite experiencing discrimination. However, focus group discussion offered additional explanations for this finding, as participants expressed seeking care even after experiencing discrimination from a provider. One participant explained how you feel after experiencing racial discrimination from a healthcare provider,

> You just don’t feel like you want hassle, you know. And that expression comes from just the visceral thought—an emotion that if you’ve gone to a doctor, even one that you thought you trusted, or whatever, and you didn’t receive the kind of treatment that you thought you were gonna receive, emotionally, physiologically almost, the next time the issue comes up you say, ‘Here we go again’, even though you know that it wasn’t about you that the treatment wasn’t as appropriate

> as it should've been. Just the thought of 'Here we go again. I've gotta find a new doctor. I've gotta do this, do that, do the other. I know I should. I'm going to, I'm going to.' But there's this little thought in the back of your mind, 'Am I gonna be facing this again? Am I gonna have to fight all over again?' And you will [seek care again]. You'll go ahead and eventually do it. But it's like, you know, it's just a feeling, and it's almost unfair to the newest doctor you go to because you bring in with you these emotions that have been there from a previous experience and you have to just work through them. Driving to the doctor's office you have to work through them, 'Okay (participant's name), this is a new doctor.' And, you know, you've done your research; you've talked to somebody; you've gotten some referrals, most likely it's gonna be okay. But, you know, you have that little dread that maybe it's not gonna be okay. And the feeling is that's always the way it is, you know. It may not be but that's what you're feeling that, 'I always have to go through something to get to what I have to get to.' And then, you know, my experience, many times, it's been okay, but you just have to walk that path. And that's racism. That's a result of growing up in a racist society where you're treated differently. Because you guard yourself, you prepare yourself to deal with the situation because you know what you're do what you can pay for—which is good health care (Participant in the 60-80 age focus group).

The participant explains that racism means continuously having to prepare yourself to fight to receive what you deserve. This is an example of vigilance—the constant fear that African-Americans carry around that they will be discriminated against. This fear can impact the physician-patient relationship, as indicated by the participant, because even when seeing a new physician, the patient still fears discrimination; "you have that little dread that maybe it's not gonna be okay". It takes a conscious effort to seek care in the future ("you have to work through your" emotions), but the participant still said she would find a new physician.

Feelings of Mistrust Toward an Unequal Healthcare System

Participants were asked to rate how much they agree with a series of statements about hospitals to determine their perceptions of the healthcare system. The results are presented in

Table 6 and show a great deal of mistrust of the healthcare system still exists within contemporary populations of African-American women.

Table 6: Responses to Statements Indicating Level of Trust in the Healthcare System

Statement	**Number that Strongly Agree or Agree**	**Number that Strongly Disagree or Disagree**	**Total Responses***	**% That Support this Statement**
Patients have sometimes been deceived or misled at hospitals	69	12	105	66%
Hospitals have sometimes done harmful experiments on patients without their knowledge	48	18	104	46%
Hospitals often want to know more about your personal affairs or business than they really need to know	29	36	105	28%
I can get sicker if I receive treatment at a hospital	5	65	105	5%
I withhold information from my physician because I fear he/she will judge me	10	87	105	10%
I do not go to the hospital or see a physician when I am sick because I fear a negative outcome or	6	92	105	6%

diagnosis				
I cannot trust my physician	3	92	104	3%
The hospital and its doctors can't do anything for me	1	102	105	<1%

A very high percentage of patients (66%) supported the statement "Patients have sometimes been deceived or misled at hospitals". In addition, nearly half of the participants (46%) believed "Hospitals have sometimes done harmful experiments on patients without their knowledge". A very small number of participants reported becoming sicker at the hospital, withholding information from their physician for fear of judgment, avoiding care due to a negative outcome, being unable to trust their physician, or being unable to receive beneficial care at a hospital. It was surprising that so few participants agreed with the statement, "I can get sicker if I receive treatment at a hospital", as one study calculated hospital-acquired bloodstream infections could cause so many fatalities to be ranked the eighth leading cause of death in the US (Wenzel and Edmond 2001). However, this could also suggest college-educated African-American women believe their regular healthcare providers can successfully manage their illnesses. Overall, the low agreement with these statements indicates that there is a strong belief in the efficacy of biomedical care and trust in individual physicians; however, there still exists immense mistrust of the medical system as a whole.

Given the hypothesis that younger participants would experience more positive experiences with the healthcare system, it was surprising that younger participants exhibited as much medical distrust as older participants. Responses to "Patients have sometimes been deceived or misled at hospitals" and "Hospitals have sometimes done harmful experiments on patients without their knowledge" by age group did not differ significantly. However, age differences in responses to, “I withhold information from my physician because I fear he/she will judge me” were statistically significant. Nine out of ten participants who indicated they did not fully share information with their provider were between the ages of 20-39. This indicates that medical mistrust may cause African-American patients to withhold information from their provider—information that is often required to provide them with adequate health care.

The Role of For-Profit Health Insurance in Exacerbating Feelings of Mistrust

Focus group discussion was very helpful in explaining the source of medical mistrust among African-Americans. Given survey respondents aged 20-39 reported the greatest distrust in the medical field, it was not surprising that this age group was also the most critical of the healthcare system. One participant commented that the hospital might not be able to diagnose a patient,

> Why go to a doctor if they’re not really gonna find what’s wrong with me anyway? [Focus group members respond in agreement]. So why pay them to tell me there’s nothing wrong, when there is something wrong, but they’re not gonna find it…You’re just gonna end up sitting here and waiting here for it to get worse eventually so why pay to have them lie to me or beg me to pay [to believe] it’s actually ok, when it’s not. And at the end of the day, it’s not until I’m really sick that they’ll realize their mistake regardless (Participant in the 20-22 age focus group).

This represents a low level of confidence that healthcare providers can diagnose a problem early enough for it to even be beneficial to seek care sooner. The participants agreed with this statement, indicating it may be common among college-educated African-American women to delay seeking care but seek alternative treatments that are perceived to be more efficacious because they feel physicians will not be able to diagnose them earlier. This comment also documents a belief that physicians make mistakes and do not catch their mistakes until it is too late and their patient is "really sick". Consequently, seeking care is viewed as a waste of money until a large enough problem manifests that cannot be controlled by the patient.

There is also a larger belief that doctors make recommendations to seek biomedical care for personal gain. In response to discussion on financial incentives for physicians who treat a large number of patients, one participant commented,

> And you might just think, 'Well of course. A healthcare provider is about to get paid [when I seek care]'. I mean, it's sad to think but at the end of the day they're gonna make money from you. It's not just like, 'Oh a friend tells you [to seek care and] there's no gain [to them]… they're just concerned with your welfare. A doctor telling you to go [see a physician] every time something hurts but you could easily take some $3 bottle of Tylenol, which if you're gonna pay $300 for a visit, you're gonna think twice [about which is more cost-effective]. [You think also about] what their motives [are], [about] what is really driving their recommendations (Participant in the 20-22 age focus group).

One of the reasons college-educated African-American women delay seeking care is because they do not feel the physician has placed the interests of their patients above the financial incentives they stand to gain. Thus, recommendations from friends to seek care may be more believed to be credible than recommendations from the healthcare provider that would treat the patient. In addition, this reaffirms the barrier cost presents to care as the costs for alternative treatments are far lower than those for conventional care. It did not seem worthwhile for the participant to seek care when there is a financial hindrance ("3 bottle of Tylenol" versus "$300 for a visit"). Another participant in this focus group blamed pharmaceutical companies,

> It's just pharmaceutical companies. [Laughter from the focus group]. No really They partner with them and tell them, 'If you sell this x amount of my pill then you get this x amount of money.' So even when this [prescription] doesn't pertain to anything wrong with you, [doctors recommend] 'You should take this' …[It's] not necessarily that you need it … [and] it's not going to hurt you but [they prescribe these unnecessary treatments] just so they can meet those demands of the pharmaceutical companies (Participant in the 20-22 age group).

The same participant later summarized, “As long as we have for-profit health insurance then it’s always gonna be this problem. Until health insurance stops being for profit and starts being for-health, then the issue is never going to be resolved”. In conjunction, these comments represent a large perception that the healthcare system places financial gain above quality treatment for patients. The opinion that pharmaceutical companies tempt physicians to recommend unnecessary treatments for financial gain may be a more individual observation, however, as the focus group laughed in response. It is unclear if other college-educated African-Americans view this as a conspiracy theory or valid claim.

Medical Mistrust Stems from A History of Poor Health Care for Blacks

Given the history of medical mistrust among African-Americans and exclusion from healthcare, it was not surprising that focus group discussion highlighted contemporary African-Americans still do not trust the healthcare system. One participant commented,

> If you take it back to our grandmothers, they didn’t trust doctors. And most of the doctors, you’re talking in the early 1900s, were white doctors, so we have a real distrust for doctors so we tend to heal ourselves. [You] got a cold, [you] drink some lemon and [inaudible do to agreement from group]. Those things still carry on today (Participant in the 40-59 age group).

A lot of the home remedies used in the past to treat sickness by African-Americans are still used today because contemporary African-Americans still do not trust doctors. Because this is documented among college-educated African-American women, it suggests greater financial security and access to biomedical knowledge have not reduced medical distrust; distrust still continues to be passed down from generation to generation. This is supported by another participant,

> I think there's still within our community—even among those of us who are supposedly educated—there's still some distrust of the medical field…We remember the Tuskegee experiment… [You read] other things: that lady… Lacks, where they took her, I guess breast cancer cells or something, she was ill, and they used them without her permission. I was just reading some of that information online… I was looking in the paper one Sunday. There was a book written about her… She was treated and then she passed but they still used her cells anyway. There's too much where they experiment on people of color. So I think even though I'm an educated person… I'm gonna make sure I read everything; I'm gonna make sure I ask questions so I'm gonna still go to the doctor. I still try to go for my annual check-ups and things especially since I'm getting older but I'm gonna also take responsibility for my health (Participant in the 40-59 age group).

The participant references the case of Henrietta Lacks, a poor Black woman whose cervical cancer cells were removed without her knowledge in 1951. The quote is key because it documents the continued sources of medical mistrust for this population: media reporting (newspapers, books, internet) on racial discrimination and experimentation on African-Americans. These experiences also occurred during the lifetime of participants and are not just stories retold by older generations that encountered racial discrimination or wrongful experimentation by healthcare providers. Although there is this knowledge and fear that a physician may wrongly experiment on women of color, it does not stop college-educated African-American women from seeking care. This contrasts the response to a lack of trust in the physician's ability, which often causes delays in seeking health care,

> I think that's a big reason why most older African-Americans now already don't seek treatment. Maybe there are stories that say that, 'My wife, or my husband, he was sick and because he was black they didn't take the time to do a simple test and now, he's passed on, but they could've checked it.' 'So why go to a doctor?', they think, or something like that. Or maybe they were just treated poorly when they did go to a doctor. Even if they got the treatment they needed, just the way they were treated as individuals made them less inclined to go [back] there just because they don't like the atmosphere or something like that (Participant from the 20-22 age focus group).

Stories of racial discrimination from a provider (the doctor “didn’t take the time to do a simple test” because the patient was black) and dissatisfaction with care, are often the biggest reasons of distrust among African-Americans. The participant most likely generalizes this comment to “older” African-Americans since discrimination was far more overt in the past, especially before the Civil Rights Movement when physicians could provide poor treatment to blacks with little consequence. These stories have caused so much mistrust that many older African-Americans do not seek treatment, and/or discontinue prescribed medication. As evidenced by the comments of focus group participants aged 20-39, distrust is also common among this generation as well.

A Strong Preference for African-American Female Physicians

Survey participants were asked to describe the race/ethnicity of their regular health provider. Those who did not have a regular provider were not able to answer this question. A very high percentage of participants reported seeing an African-American physician (61%). Similarly, a very high percentage reported seeing a female physician (66%). Most participants were seen by a physician who had been practicing for at least 10 years (68%).

Table 7: Physician Characteristics

Characteristics of Regular Provider	Study Population	Percentage
Physician Race/Ethnicity		
African-American/Black	56	61%
White	28	30%
Asian	1	1%
Hispanic	0	0%
Other	7	8%
Physician Gender		
Male	31	34%

Female	61	66%
Number of Years Physician Has Practiced		
0-5 years	1	1%
6-10 years	6	7%
11-15 years	18	19%
16 or more years	45	49%
Don't Know/Unsure	22	24%
Total Responses	92	100%

As evidenced by Table 7, the overwhelming majority of study participants were seen by African-American physicians. This is an indirect indicator of a strong preference for African-American female physicians within this population. As college-educated women, these women have greater accessibility to physicians and an ability to change physicians if they do not like their provider. Focus group discussion offered numerous explanations for the preference for a same race physician, including supporting other African-Americans in their endeavors,

> I support my doctors. My first preference is African-American just because, to support my community, support black business… And the doctors I have who are not black doctors is because someone referred me to them and they were good [Agreement from focus group]… But my first preference is always a black dentist, podiatrist, anybody (40-59 age focus group participant).

This quote indicates that there is a strong preference for an African-American physician but women will see physicians outside of their racial group if they have been strongly recommended. Participants were in agreement with this statement, indicating it was not just the perception held by the speaker but by the group. This sentiment was similarly expressed by another participant in the 40-59 age focus group, who described disappointment when a recommended physician was not black. She stated she would only see this physician with the encouragement that the physician was "really good". Even though African-American women may be disappointed that they cannot find a same-race physician, they will still seek care from a physician from another race as long as they receive the assurance that the physician will provide excellent care.

Participants stated they would search very hard just to find an African-American physician. One participant commented,

> I'm from Wisconsin so finding a black doctor in Wisconsin sometimes is like finding a needle in a haystack. So, being a part of a sorority, you know, when you had a black doctor, of course everybody wanted to go to her—to the point where she literally had to stop taking patients because she just couldn't take anymore. So when you hear about another black doctor in the city it's like, 'Okay, let me see if I can hurry up and call and get on their list.' (Participant in the 40-59 age focus group).

This opinion reinforces the strong preference for African-American physicians; so many patients desired to be treated by this physician that she could not see them all. In addition, African-American women have used the sorority as one way to find an African-American physician when they were not easily accessible. There were other practices too, as expressed by another participant in the 40-59 age focus group, "I would be in the insurance book at work and, especially now that we have the internet, I'll pull them up, because I'm looking for someone who's black". Members from the focus group expanded this comment by highlighting characteristics that indicated a physician was African-American, " A picture, medical school? Oh, Howard, okay. A member of our sorority. [Or any] identifier." The women searched for biographical information on a physician that would indicate he/she was black. Other than observing skin color from a picture, participants searched for more subtle identifiers such as being a member of a black sorority. Attending a historically black medical school, such as Howard University, would also indicate that a physician was black. These methods were used to increase the chances that participants would be treated by the physician of their choice.

“I Don’t Care If You’re Green”—A Lack of Physician Preference Among Older Generations

Although the 20-22 and 40-60 age focus groups expressed a strong preference for a same race physician, three out of four of the 60-80 age focus group participants stressed that physician race was not as important. One participant stated, “I don’t [have any racial preference for a physician.] I have both black and white… I try to get the best [physician] that I can. I don’t care if you’re green. If you’re green and you’re the best in that area, that’s who I need [to see]. So I have no preference”. The participant used a skin color that does not exist to stress her point that she preferred a physician who was the best, regardless of skin color. Because of the lack of preference for the race of a physician, 60-80 year old participants described a different process for finding a physician than women in the other two focus groups. One woman described obtaining recommendations for physicians from friends,

> I really want recommendations from people for physicians and that’s what I basically look for… I’m listening to [another participant] over there talk about her physician and I look for what kind of physician they are, you know, … what their emphasis [on patient care] is (Participant in the 60-80 age focus group).

Instead of searching online for physicians, this woman listened to her friends describe the type of care they received and decided to seek those who were highly recommended and treated patients how she would like to be treated. Another participant had moved to Atlanta with her husband four years ago and had to find new physicians. While all of her physicians in Buffalo were white, “for whatever reason”, she looked for the best when she arrived in Atlanta. She was able to find both white and black physicians to treat her but stated, “it’s really hard to find people [to treat you]. You think you’re getting the best … you just go by the research and the reputations”. This echoes the value of researching the reputation of the physician and obtaining recommendations from friends.

Gender Makes A Difference

In general, preferences for female physicians were less strong than those for African-American physicians. However, there were quite a few participants who agreed that gender makes a difference in the quality of care they receive. Women in the 60-80 age focus group especially expressed a preference for female gynecologists. One participant stated, "I prefer female gynecologists. I've had both black and white... All kinds of physicians and I really do prefer black physicians and I prefer black females if I can find them. I will not sacrifice quality care." As with racial preference for physician, this age group expressed that the type of care the physician provides is more important than his/her race or gender. One participant in the 40-59 age focus group described her excitement when she was able to have only black female physicians after moving to Atlanta,

> P: I have had black male [physicians] and then when I moved here, all of my doctors were black and female and I was like 'Yes!'
> BM: What difference did that make for you?
> P: It was just, it was a choice. I had a choice and I just thought that I could talk to a female better about more things than I could a male, you know. He may say something and I'm like, 'What?'.

To the last comment, another participant responded that male physicians often have "no clue" what African-American women are talking about when they describe their health problems. Participants felt their health care is even better when they have African-American female doctors because they will be better understood.

Better Cares Comes from an African-American Physician

Focus group participants discussed their reasons for perceiving better quality care when being treated by an African-American physician. One of the reasons is "ability to relate", or "relateability". This was mainly discussed in the 40-59 age focus group but due to the high percentage of women in the focus groups of other age groups, this is probably a shared sentiment. African-American women value being able to explain their problems and have their physician understand them because they often encounter similar health problems. This was described by one participant in the 40-59 age group, "I think it's ability to relate and you figure she's relatable because she's African-American. And when I tell you something I don't wanna sound stupid … [I feel it's] 'Oh, okay, You get me'… I think it's just a comfort and familiarity". African-American women are often more comfortable explaining their conditions to African-American females because there is not a risk of being perceived as being "stupid" due to a greater "familiarity" with the health problems African-American women encounter. They want physicians to "get" them. Participants felt having something in common led to more open communication with a physician, "You definitely have to be comfortable with your doctor. Something that motivates you to increase, you know, communication. Relateability" (Participant from the 40-59 age group). In addition, having an African-American physician may lead to greater trust in one's physician. Another participant commented,

> I think that [seeing an African-American physician] kind of … assuages the fear that you might not be getting all of the attention that you deserve…If there's something that you could be at risk for, she would know about that… [She would] be able to relate more with the patient (Participant from the 20-22 age focus group).

African-American women are less concerned that they are not receiving adequate care when treated by an African-American physician. They perceive African-American physicians have more knowledge of the health problems of African-American women because they may have also faced them. This can help increase trust in and reliance on biomedical health care.

Barriers to Care: High Costs and Self-Pride

In addition to highlighting the factors that have shaped the health behaviors and attitudes of college-educated African-American women, survey and focus group data have also emphasized the barriers to health care that this subgroup continues to face. Financial and cultural barriers remain despite the higher social class of these women. The exploration of these barriers is critical to provide insight into the impact of social class and culture on health behaviors.

Financial Barriers to Health Care

Multiple survey questions asked participants about their access to regular health care; these results are presented in Table 8. As predicted, the overwhelming majority of study participants had health insurance coverage and a regular health care provider; only 5% of survey respondents indicated that they did not have health insurance. Five percent of respondents also indicated that they did not have a regular health care provider. All of the 5 who reported not having a regular health provider were in the 20-39 age range. Of these 5 respondents, 1 did not have insurance coverage and 2 were undergraduate students, which help explain the lack of treatment by a regular healthcare provider. In addition, the majority of survey respondents had been treated by a physician within the past year; only 11% of participants had not seen a physician within the last year. Of the 11 persons who had seen a physician between 1-5 years ago, 10 were between the ages of 20-59.

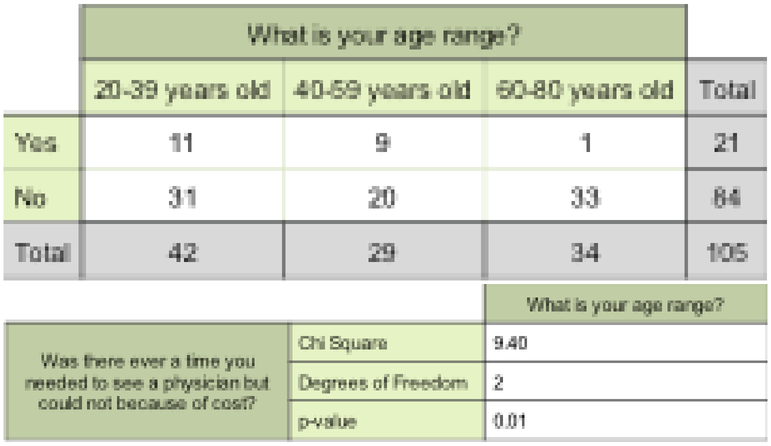
Table 8: Estimates of the Financial Burden Posed by Cost of Care

Survey Measure	**Study Population**	**Percentage**
Health Insurance Coverage?		
Yes	100	95%

No	5	5%
Total Number of Responses	105	100%
Regular Healthcare Provider		
Yes	99	95%
No	5	5%
Total Number of Responses	104	100%
Could Not Seek Care Due to Cost		
Yes	21	20%
No	84	80%
Total Number of Responses	105	100%
Length of Time Since Last Physician Visit		
Less than 6 Months	82	78%
6 Months-1 Year Ago	12	11%
1-2 Years Ago	8	8%
2-5 Years Ago	3	3%
Over 5 Years Ago	0	0%
Total Number of Responses	105	100%

Given nearly all respondents had health insurance coverage, it was surprising that 20% still reported they had been unable to seek biomedical care at some point due to the cost of health care. Responses to "Was there ever a time you needed to see a physician but could not due to cost?" were further analyzed by age group. Results are presented in Figure 1.

Figure 1: Responses to "Was There Ever a Time You Needed to See a Physician but Could Not Because of Cost?"



	What is your age range?			
	20-39 years old	40-59 years old	60-80 years old	Total
Yes	11	9	1	21
No	31	20	33	84
Total	42	29	34	105

		What is your age range?
Was there ever a time you needed to see a physician but could not because of cost?	Chi Square	9.40
	Degrees of Freedom	2
	p-value	0.01

Those most likely to encounter financial barriers to care were participants ages 20-59. Out of 21 respondents who indicated cost had prevented them from obtaining care, 20 were between the ages of 20-59. It was surprising that by age group 26% of participants aged 20-39 and 31% of participants aged 40-59 reported limited access to care. Four out of the 11 persons in the 20-39 age group were undergraduates, which indicates African-American college students may not be able to receive the care they need because of cost. On the other hand, it is positive that the oldest age group did not encounter financial barriers to care. As the age group that often requires the greatest number of yearly physician visits, respondents in this group have been able to obtain the care they need.

As a follow-up question to financial barriers to care, participants were asked how they treated themselves when they could not seek care. The responses are presented in Table 9. The great majority of participants reported utilizing self-treatment (86%) or seeking advice from a friend/family member in the healthcare profession (48%). These results are quite different from those presented in Table 2, which assessed treatment during last sickness episode. Only 17% asked for advice from a friend/family member in the healthcare profession during their last sickness. In addition, 4% reported visiting the emergency room and 2% reported waiting until the symptoms abated without seeking a treatment. In contrast, Table 9 displays 14% of participants reported visiting the emergency room for care and 14% reported waiting until the symptoms abated without seeking a treatment. This may imply that when cost is a barrier to care from a general practitioner, college-educated African-American women may visit the emergency room or not seek any remedy for treatment. Consequently, there may be significant time period in the lives of college-educated African-American when they do not obtain care—from the age of 20 until the age of 59. Often care obtained once chronic illnesses manifest is too late to prevent a negative health outcome.

Table 9: Treatment Utilized When Cost Presented a Barrier to Seeking a General Practitioner

Treatment Methods (N=21)	Affirmative Response	% Yes
Treated yourself (home remedies, over-the-counter medicine, self-diagnosis, etc.)	18	86%
Asked a friend, family member in the healthcare profession for advice	10	48%
Pray, Read the Bible	4	19%
Asked a friend, family member outside the healthcare profession for advice	4	19%
Visited the emergency room for care	3	14%
Did nothing, waited for symptoms to stop	3	14%
Sought care from an alternative healer	1	5%

Focus group participants similarly emphasized that cost has presented a barrier to health care. One participant commented,

> Cost is an issue…The first thing they ask for when you walk through the door is, ‘Do you have insurance? Or how [are] you gonna pay?’ and, fortunately, there are some of us [who] have good insurance, and we can just go in and we can write a check. There are many, and I [even] know of middle and *upper* class black folk, who cannot; who don’t have insurance due to loss of job or other circumstances; who don’t have the cash to go in there. So that’s a great impact on [the health care] we receive, (Participant in the 60-80 age focus group).

The 60-80 age focus group was the only group that all participants reported they could pay for the health care they needed. Participants in the other two focus groups reported cost of care is too expensive. This comment illuminates that there are many African-Americans, including middle and upper class African-Americans, who cannot pay for the care that they require either because of lack of insurance coverage or other circumstances. Because many African-American women cannot afford the cost of care, they have been forced to make the difficult decision to not seek care. One participant comments,

> I believe that there's still a large portion of us [college-educated African-American women] who we are watching every single penny we have. Maybe it's because we're single parents, I don't know. I wish I knew when this whole co-pay thing really started because I hear people at work saying all of the time, you know, I'm not going to the doctor, I'm not paying that $35 co-pay. So I know that co-pay is stopping a lot of people from going to the doctor (Participant in the 40-59 age focus group).

This belief suggests that even with health insurance coverage, the cost of health care is still too high for some African-American women. Part of the reason that cost is still an issue for this subgroup is because having a college education does not guarantee one can find a job with adequate health benefits. As expressed by a participant,

> You [make sure you] do well enough to get a good job so that you can get benefits so that should things happen, … you can have insurance that will cover those things or you can afford to get the medicine that you need. You can be black and college- educated and still have a part-time job with no benefits and if something happens where you need to be hospitalized, [or] you have to be on dialysis or something, you can't afford that. Your education's not going to help you because you don't have any way to pay for it (Participant in the 20-22 age focus group).

Cost is still an issue because not all college-educated African-American women receive adequate health benefits or can pay for their care. This participant believed that a college education is not helpful unless a job with ample health benefits and/or a high salary is obtained. Middle-class blacks may be in one of the worst positions to pay for their care. One participant commented,

> I feel like most of the time the middle class gets the shortest end of the stick. Like, I don't even know if they get to touch the stick. [Group laughs]. They just get beat with it. [Laughter continues]. No, because like, poor people get a lot [of financial support]. Yes, they need it but they get it. Rich people can afford it. Middle class? Hmph (Participant in the 20-39 age focus group).

While a college education has offered African-American women greater access to a better lifestyle, it has not eliminated the barrier to obtain care among middle-class blacks. This belief implies that upper class blacks can afford to pay for their health care and lower-class blacks often receive assistance from the government to pay for their health care but middle-class blacks neither receive assistance nor have the money to pay for their care. As a result, the participant feels they encounter the "shortest end of the stick". This is discerning as financial barriers prevent African-Americans from receiving preventative care—care that if received could help reduce health disparities.

Pride in Self-Treatment

When asked about additional factors that can impact the health care of college-educated African-American women, participants mentioned that African-American women utilize self-treatment more than biomedical care due to pride. A part of the pride comes from an unwillingness to admit to needing help. This is described by a participant from the 20-39 age focus group,

> I'll also say … a sense of pride [impacts willingness to seek care] … you don't wanna always have to ask for help [from a physician] because you feel like people already think you're not capable enough to do other [things]… general people do I guess. … you might not be so willing to ask for help or admit that you might need help so that might prevent you from going to the doctor…If you think something might be wrong, you might just want to ignore it (Participant in the 20-39 age group).

The unwillingness of African-American women to seek care seems to stem from a fear that someone will view them as being weak or incapable of helping themselves. The participant also indicates that others already view blacks as being less capable of doing tasks that other non-minorities are fully capable of doing. Perhaps, African-Americans do not want to admit they need help treating themselves so that they can show that they are capable of doing something: treating themselves. Self-treatment and self-reliance seem to bestow a sense of pride that decrease reliance on biomedical care.

A sense of pride can hinder the health care of college-educated African-American women. This pride poses conflict across generational and gender lines. Study subjects explained that men have kept their illnesses and health behaviors from women; parents have kept this information from their children. One participant in the 60-80 age focus group describes her experiences in trying to care for her mother,

> My mother is 91 so there were some years she wouldn't let me use some of the new knowledge that I have [to help her] not lose her sight. She did end up losing her sight [due to maculative degeneration], and had been basically a healthy woman all those years. And that has caused a real difficulty for her now in her senior-senior years… And that [disease] you cannot prevent but if you catch it early enough… I'm not even sure. I didn't even research it as much as I would've liked because she hid it from me for so long. … I actually discovered the lady couldn't see and I thought to myself, 'This lil' old lady can't see! She's hiding something from me!' But that was her own pride in taking care of herself. So one of the things that I'm trying to learn from her is to… either take care of myself or to try to be a little bit more open with [my kids] so that they don't have to go through that kind of emotional frustration that we could've helped but she wouldn't let us. But it's kind of difficult when some of the barriers are [hard to overcome]… Just because you're educated that doesn't mean you know everything. And that's something that I deal with between me and my mother (Participant from the 60-80 age focus group).

The participant's mother was so determined to protect her pride that she did not even admit to her daughter that she had lost her sight. It is important to note the impact the experience had on her daughter. Rather than feeling as if she knew everything and did not need to seek treatment from a physician, the participant expressed trying to be more open about her health problems with her children. She wished to spare them from the frustration of not being able to prevent a negative health outcome because she did not tell them about her illness nor seek biomedical care.

Improving the Health Care of College-Educated African-American Women

Participants were asked to indicate how strongly they agreed with a series of statements about factors that could improve their health care. Barriers to care were examined across race, gender, and socioeconomic class levels. The results are presented in Table 10.

Table 10: Factors that Could Improve the Health Care of College-Educated African-American Women

Statement	**Number that *Strongly Agree* or *Agree***	**Number that *Strongly Disagree* or *Disagree***	**Total Responses***	**% That Support this Statement**
I would receive better health care if I had better health insurance	46	35	104	44%
I would receive better health care if I made more money	44	43	105	42%
I would receive better health care if I had a female physician	28	41	105	27%
I would receive better health care if I had an African-American physician	18	47	105	17%
I would receive better health care if I was white	22	58	105	21%
I would receive better health care if I was a male	12	66	105	11%

I would receive better health care if I had a younger physician	9	45	105	9%
I would receive better health care if I had an older physician	9	52	105	9%
I would receive better health care if I was younger	6	74	105	6%
I would receive better health care if I was older	3	79	105	0%
I would receive better health care if I had a male physician	1	52	105	>1%
I would receive better health care if I had a white physician	0	63	105	0%

Most participants felt improving their socioeconomic status and health insurance plans would help improve their care. Table 10 shows that 44% of participants indicated they would receive better health care if they had better health insurance while 42% stated they would receive better health care if they made more money. Over a quarter of participants indicated they would receive better care from a female physician, while less than 1% stated they would receive better care from a male physician. This reflects the greater preference for a female physician due to increases in quality of patient care that were discussed in this chapter. Similarly, over 17% of participants indicated they would receive better care from their physician if their physician was African-American while 0% felt their care could be improved by having a white physician.

These results provide greater support for the preference for an African-American female physician by college-educated African-American women. It was not surprising that 21% of participants felt they would receive better health care if they were white given the large amount of literature on racial disparities. Participants did not feel changing the age of their physician, nor their gender or age would have an effect on the care they received; very few participants agreed with each of these statements.

Upon performing cross-tabulated analyses of the above statements by age group, only one analysis was statistically significant: responses to “I would receive better health care if I made more money”. When examined by generation, the 20-39 age group was statistically more likely to agree or strongly agree with this statement than any other age group, as presented in Table 11. Specifically, 28% of persons aged 20-39 agreed or strongly agreed with this statement while only 14% of participants aged 40-59 and 8% of participants ages 60-80 agreed or strongly agreed with it. Because the 60-80 age group was the least likely to agree with this statement, this may reflect greater financial security. This again reinforces the possibility that there is a gap in the health care of college-educated African-American women, despite their higher SES and educational levels.

Table 11: Responses to, “I Would Receive Better Health Care if I Made More Money” By Age Group

	Age Group (N=87)		
Condition	**20-39**	**49-39**	**60-80**
Either Agree or Strongly Agree	25	12	7
Either Disagree or Strongly Disagree	12	12	19

In the focus group discussion, however, participants stressed improvements in health insurance would be one of the greatest measures to improve the health care of college-educated African-American women. When asked how participants felt their health care could be improved, one participant responded,

> I need some money. Right now the insurance situation [is] atrocious, so clearer insurance rules and regulations, and laws, and stipulations [would also help]. Things are just in such a flux that you can spend lots of time doing the research, talking to people, talking to your physician and you still have to make the decision as to what you're gonna do every year. And sometimes you come up short. Even with the best of intentions. I was told recently that my decision was not a good decision. My physician's office told me, 'You are in a pickle of a situation but many people's are worse than yours. You have made the best decision that I think you could make given everything that I know.' This was an office administrator [who said this], and I thought, 'What?' She said, 'Yeah. You're in better shape than many of our patients. And you're right, yours isn't all that great'. And that's about the insurance industry, not about the health care that I get from this physician (Participant from the 60-80 age focus group).

Because the current insurance situation is "atrocious", it needs to be reformed because it is presenting a barrier to care to even those who live well above the poverty line (78% of study participants reported a total annual household income of greater than $50,000). In addition, it forces African-American women to make difficult decisions about their care. Although the participant was more than likely in a better position to control her health care due to her greater socioeconomic status ("you're in better shape than many of our patients"), she similarly faced health disparities.

Chapter 6: Discussion

Previous research has largely ignored the impact of age and social class on the health behaviors of African-Americans, citing only race/ethnicity as a significant determinant of health practices. Missing from the literature is information on the health attitudes, beliefs, and behaviors of college-educated African-Americans, and the cultural, racial, and socioeconomic factors that have influenced these health practices. As one of the first studies to examine the independent effect of a college education on the health behaviors of African-American women, this study has several key findings. Firstly, race, social class, and culture have had strong roles in shaping the health behaviors and beliefs of African-Americans. While higher SES results in greater access to care for African-American women, higher income alone cannot fully eradicate the health disparities faced by this population. As a result, college-educated African-American women still rely heavily on self-treatment and alternative medicine during episodes of sickness. Second, this study offers further insight into treatments used by African-Americans at home. In addition to prayer, advice from friends and family, and home remedies (which are detailed by Barnett 2003 et al. and Barzargan et al. 2005), participants also reported utilizing over-the-counter medicine, herbal remedies, and vitamin therapy. In contrast to the literature on the health behaviors of low-income African-Americans (Bailey 1988; Barnett et al. 2003; Barzargan et al. 2005; Bogart 2001; Brown and Segal 1996; Heurtin-Roberts 2002; Schoenberg 1997; Snow 1993), study participants did not report seeking care from a folk or spiritual healer. These findings differentiate the health behaviors of college-educated African-American women from African-American women with a high school education or less.

Notions of Ideal Health Behaviors

College-educated African-American women strongly believe in the importance of complementing biomedical care with alternative treatments for their health and well-being. This belief mainly stems from the perception that healthcare professionals overmedicate their patients and often prescribe medications without researching alternatives to prescriptions. Similarly to Bailey's findings (1988), participants were unwilling to depend heavily on prescription medication. They instead wanted to balance their treatments to avoid completely relying on one source of care, stating "too much of anything is bad". As a result, participants reported using both folk and biomedical treatments including over-the-counter medication, home remedies, and prayer. They also preferred more "holistic" and "natural" treatments such as vitamin therapy and home remedies. This is an important discovery because it distinguishes the health behaviors of college-educated African-American women from those of less educated African-American women. While the literature reports lower-class African-American women utilize home remedies and folk healers as their principal forms of treatment (Bailey 1988; Barnett et al. 2003; Barzargan et al. 2005; Bogart 2001; Brown and Segal 1996; Heurtin-Roberts 2002; Schoenberg 1997; Snow 1993), college-educated African-American women utilize care from a physician, vitamin therapy, over-the-counter medicines, prayer/religion, and home/herbal remedies. In addition, very few participants reported seeking advice from their family and friends for treatment. This suggests that college-educated African-American women are relying on biomedical knowledge more than less-educated African-American women.

College-educated African-American women exercise much control over their care; they strongly support researching their own conditions and possible treatments to ensure they receive an accurate diagnosis. As this was not highlighted in the literature on lower-class African-

Americans, the extent to which other social classes of African-Americans research their conditions is unknown. In the case of college-educated African-American women, research is used to ensure a “proper diagnosis”. College-educated African-American women often feel that they make well-informed decisions regarding which treatment plans to follow because there is a great amount of information available about illnesses. Thus, self-treatment is still believed to be essential to proper health care, not because of limited healthcare access, but because it offers more “holistic” and “balanced” care. Study participants discussed utilizing their continued education to understand treatment options and ensure they made the best decisions for their health, even if their choices contrasted those of their physician.

Participants also articulated that effective communication between a physician and patient is fundamental to African-American women receiving equal care. Focus group discussion among participants aged 60-80 indicated that African-American women can potentially have poor health outcomes because they do not demand better care from their physician when they perceive they have received unequal treatment. Lower-class African-American women were believed to have the worst health outcomes because they have lower health knowledge, and cannot recognize when their care is not adequate nor afford to seek additional care. Middle- and upper-class African-American women, on the other hand, often have the advantage of seeking second diagnoses from physicians when they are not satisfied with their care. This greater control over their care is presumably another way higher SES improves the health behaviors and reliance on biomedicine among African-American women.

The Factors That Shape Health Behaviors

Survey results demonstrate the health perceptions and practices of college-educated African-American women are quite different from those documented in the literature on lower-class African-Americans. Low-income African-Americans have been reported to primarily rely on self-treatment and folk medicine due to poor access to medical services (Barnett et al. 2003; Barzargan et al. 2005). In contrast, participants in this study were most likely to seek care from a physician during their last sickness episode (Table 2), although this frequency varied by age group. This indicates that with higher SES, African-Americans are able to utilize mainstream medical care more frequently.

This research project expands the literature on the health behaviors of African-Americans by identifying additional factors that can cause African-Americans to utilize alternative medicine outside of financial barriers to care. One factor is pride from self-treatment. Focus group participants expressed that such pride can cause delays in seeking care from a physician. African-Americans are often pleased when they do not rely on help from a physician, but are instead able to heal themselves. These actions are believed to demonstrate strength and ingenuity. In contrast, seeking care from a physician is often construed as a sign of weakness and an acceptance that one does not know everything. In some cases, pride also even extends to acknowledgment of illness to family members. One participant in the 60-80 age focus group indicated that she had to discover her mother was blind; her mother did not reveal this information to her because of her pride. As this was the only case mentioned by focus group participants, this may be a characteristic of past generations, as generations in this study appeared to be more forthcoming with information on their illnesses to their family and friends. However, this does not mean that study participants were more likely to rely on advice from family and friends. As less than 20% of participants sought advice from their friends, this may indicate that college-educated African-American women are relying mainly on their own knowledge to treat themselves.

This study also examined the impact of racial discrimination and medical mistrust on health behaviors. Participants rarely reported experiencing discrimination from a provider. In contrast to the existing literature (Barzargan et al. 2005; Benkert et al. 2006; Casagrande et al. 2007; O'Malley et al. 2004), the results of this study indicated neither racial discrimination nor medical mistrust caused delays in seeking care nor compliance with physician recommendations. However, results do indicate that racial discrimination is a significant psychosocial stressor for college-educated African-American women. One participant in the 60-80 age group described that encountering discrimination from a provider would not prevent her from seeking care from another physician in the future, but would cause a constant fear of experiencing discrimination from the new provider. However, this fear of discrimination may cause some African-Americans to withhold information from their provider, as 21% of participants aged 20-39 indicated they would withhold information from their provider for fear of judgment. Only one focus group participant mentioned that disrespect from a provider may decrease compliance with physician advice. This participant further commented that following disrespect from a provider, African-Americans may seek alternatives to biomedical care, such as prayer/religion, for treatment. As Flores 2000 emphasizes, this may also impact the physical health of African-Americans.

Study results also support Gamble's work (1997), who determined mistrust still exists among African-Americans due to the continued documentation of unfair treatment from healthcare providers. In the 60-80 age focus group, participants mentioned the case of Henrietta Lacks, a poor Black woman whose cervical cancer cells were removed without her knowledge in

1951. Quantitative data also evidenced distrust in hospitals, as the majority of participants felt patients have sometimes been deceived or misled at hospitals (66%), and hospitals have sometimes done harmful experiments on patients without their knowledge (46%). This indicates that higher educational levels do not necessarily erase negative perceptions of the healthcare field. However, these perceptions did not impact willingness to seek care. Medical mistrust is still being documented among African-Americans, but contrary to existing research (Barzargan et al. 2005; Benkert et al. 2006; Casagrande et al. 2007; O'Malley et al. 2004) it may not pose a barrier to biomedical care for middle-class African-American women as it does for lower-class African-American women. Consequently, the impact of racism on the health behaviors of African-Americans may lessen with increasing SES. As distrust was still documented among the youngest participants, results suggest a cultural inheritance of distrust—youngest participants still had knowledge of unethical experimentation and unequal treatment as such stories have been passed down from generation to generation, and through popular literature. The nature of medical mistrust may be changing, however, as younger participants reported less confidence in their physician's ability to diagnose them before they got "really sick", while older generations mainly reported they still fear discrimination from a provider.

Age May Not Be a Strong Indicator of Health Behaviors

Results yielded very small differences in the health behaviors of college-educated African-American women across generations; their health behaviors echo those of their parents and grandparents. All three age groups, for example, believed in the importance of researching their conditions and balancing their treatments to ensure the highest quality of health care. One of the few differences in the generational health behaviors involved treatment during last sickness episode. Participants aged 20-59 were far more likely to self-treat themselves when they were last sick than participants aged 60-80, who primarily sought care from a physician. Differences in self-treatment are largely due to differences in healthcare access. As younger participants experienced greater financial barriers to care, they utilized self-treatment as their main form of care because it was less expensive. However, this may not be the only reason for increased reliance on self-treatment. Though patterned by others' health behaviors, health behaviors are still an individual's choice; participants did not always follow the recommendations of their parents/grandparents or utilize the same treatments as them for the same illnesses. Consequently, variations in treatment may also be because younger generations may have contrasting opinions from their parents about which treatments they should use.

Revisiting the Physician Preferences of African-American Women

Study results contribute to previous research demonstrating that African-Americans prefer African-American physicians (Gray and Stoddard 1997; Moy 1995). A very high percentage of participants reported seeing an African-American physician (61%). Similarly, a very high percentage reported seeing a female physician (66%). Focus group discussion offered numerous explanations for the preference for a same-race physician, including supporting other African-Americans in their endeavors, and perceptions that African-American female physicians can better relate to their health concerns. This research indicates that college-educated African-American women first try to seek care from African-American physicians, and then decide to see a physician of a different race only if an African-American physician is unavailable and the non-black physician is highly recommended by others. To ensure they were seen by an African-American physician, participants described undertaking several measures, from researching the physician online to find racial identifiers, to networking through the sorority. However, this preference was mainly among participants aged 20-59; older participants refused to sacrifice quality for a same-race physician and stated they wanted the best doctor available regardless of a physician's race or gender.

Focus group participants perceived greater quality care when being treated by an African-American physician. One of the reasons is the "ability to relate", or "relateability". This was mainly discussed in the 40-59 age focus group but is probably a sentiment shared by the 20-22 age focus group as well. Participants declared not wanting to "sound stupid" when describing their health problems to male physicians—the lack of relateabilty to women posed a communication barrier between male physicians and female patients. Participants felt greater "comfort" and "familiarity" in discussing their health concerns with a female physician. They felt having an African-American physician may lead to greater trust in one's physician.

This strong preference for an African-American physician has several implications for the care of African-Americans. Having a same-race physician decreases the perceived risk of experiencing racial discrimination, as little intragroup discrimination has been documented in previous studies (Clark et al. 1999), and increases length of visit, satisfaction with care, and perceived participatory decision-making (Cooper and Roter 2003). Participants also felt African-American female physicians would be more likely to know the health conditions that disproportionately affect African-American women and could offer advice on effective alternative treatments that are compatible with the cultural health practices of this subpopulation. Racial concordance in healthcare visits improves the health care of African-Americans on multiple levels. Although Street et al. (2008) concluded personal similarity with physicians increased patient trust, satisfaction, and adherence to care more strongly than racial concordance, participants from this study did not seem to support this claim. In contrast, they valued a physician who looked like them and would experience the same health problems as them. Because only 5.8% of US physicians are black (U.S. Bureau of Labor Statistics), African-Americans are not likely to be treated by physicians with whom they feel most comfortable. These findings also suggest that cultural competency (i.e. informing providers of cultural health behaviors and perceptions) may not be effective in increasing trust and adherence to care when an individual displays a preference for a same-race physician but is treated by a non-black physician.

The Benefits of Higher Education: Financial Stability and Greater Access to Care

One of the unique aspects of this study is that it included only college-educated African-American women. This allowed the independent effect of obtaining a college degree on the lifestyles of African-American women to be studied. Overall, college-educated African-American women experience greater financial stability and economic mobility than do African-American women with less education. The US Census Bureau reports the average yearly income by educational level of African-American women was $23,195 for high school graduates but 42,858 for college graduates in 2008. Household income is often higher than individual salaries for college-educated African-American women, as 78% of participants reported a total annual household income of greater than $50,000/year (Table 1), resulting in greater total wealth. In addition, only nine participants out of 106 (8%) reported being unemployed or self-employed, suggesting that a college education has afforded almost all study participants financial stability and economic success. It appears that college-educated African-American women enjoy more affluent lifestyles than women with less education.

In addition, having a college-education has improved the overall health of African-American women. As reported in Table 1, 68% of respondents reported a health status of either excellent or very good. In contrast, only 5% of respondents reported they were in fair health and 0% reported being in poor health. These reported health statuses are much better than those reported by African-American participants in the 2009 BRFSS. Nationally, only 42.5% of African-Americans reported being in excellent or very good health, while 15.2% reported being in fair health and 5.0% reported being in poor health. Study findings are in concordance with literature that details a college education increases the health status of African-Americans (LaVeist 2005).

One of the reasons a higher educational level increases health status for African-Americans is because it improves access to care. As reported in Table 8, 95% of the study population had health insurance coverage. Similarly, 95% of the study population reported being seen by regular provider. In contrast, the 2009 BRFSS reports that only 79% of African-Americans have insurance coverage. Because research has indicated that the quality of care improves when a patient has a regular healthcare provider who is familiar with the patient's health (Politzer et al. 2001), greater access to a regular physician has enhanced the health care received by this study population. An additional factor is that college-educated women do not rely on the emergency room for care like African-Americans who lack adequate insurance coverage or cannot afford preventative care. As highlighted in Table 4, only 4% of participants reported visiting the emergency room for treatment during their last sickness episode, while 62% visited a general practitioner.

Cost Is Still an Issue

However, despite greater financial stability and markedly higher incomes, cost still presents a significant barrier to obtaining health care for college-educated African-American women. As presented in Table 8, 20% of participants reported they were not able to see a physician due to cost. Further analysis revealed participates aged 20-59 were least likely to receive care when needed (Figure 1). Women in the 20-39 age group were also the only women to report they lacked a regular health care provider; women aged 40-80 all reported having a regular health provider. This is a critical finding because it indicates that young college-educated African-American women may not be receiving necessary preventative care. Because disease outcomes can worsen with delays in seeking care, chronic conditions or serious illnesses may not be discovered until it is too late to treat them effectively. However, it is a positive finding that the oldest age group (60-80) reported being able to seek care whenever needed, especially since their health care is often the most expensive due to complications from chronic conditions. This may also indicate that college-educated African-American women aged 60-80 have an insurance plan that allows them certain additional benefits due to their age.

Focus group discussion indicated that college-educated African-American women have decreased access to care for a few reasons. Although the majority of college-educated African-American women have health insurance, there is a small minority of women who neither have health insurance nor can pay for care. The black middle class is often faced with difficult decisions to make regarding seeking treatment. There are several middle-class African-Americans who do not seek care because it is too expensive[17]. One participant even stressed that

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[17] Discussion during the defense of this thesis generated possible reasons for why cost is still perceived as a barrier to care even with higher SES. Firstly, middle-class African-Americans often come from a low-income background and still carry the mindset and behaviors of low-income African-Americans. Consequently, they may perceive cost

the black middle class often has the most difficult time financing health care because they neither receive support from the government nor have the money to cover the cost of their treatment. Although a college education has afforded African-American women greater access and health insurance coverage, more efforts need to be made to reduce financial barriers to care so that the nation's adult population can continue to be healthy and thriving in old age.

Implications of Study Results for the Health Care of African-Americans

This research suggests that higher SES increased access to care and health insurance coverage in a population of college-educated African-American women. Despite also increasing reliance on biomedicine, biomedical care was still complemented with alternative medical care, such as prayer, home remedies, herbal therapy, in order to maintain a balance among health care treatments and offset financial barriers to care. Participants aged 20-39 were most likely to experience financial barriers to care, which caused heavy reliance on folk and other forms of alternative medicine during times of continued education and unemployment. Due to limited access to care, African-Americans will continue to face health disparities, as study results indicate they are not currently receiving adequate preventative and therapeutic care before the age of sixty.

Participants were very critical of the healthcare system and provided concrete ways in which their health care can be improved. Firstly, participants believed better health insurance and greater financial success would improve their health care. Second, participants articulated that

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of biomedical care is too high when their parents were able to heal themselves by using folk medicine. In addition, $50,000/year in a black household does not equate to $50,000/year in a white household due to less job security, higher percentages of single-parent homes, and the propensity to live beyond one's means in order to demonstrate membership in a higher social class. The number of generations occupying middle class status also impacts health behaviors. Participants may also think cost is too high for their type of sickness; it may not be worth it to seek a physician something minor and pay $300.

physicians need to be more willing to research alternatives to prescription medicine, especially for patients who are unwilling to rely on prescription medicine for long-term treatment of chronic illnesses. In addition, mistrust in the healthcare system can be further eliminated by increasing the number of practicing African-American physicians, due to increased trust in provider ability from matching patients with the physician of their choice.

This research raises numerous questions that need to be addressed in future research on the health behaviors of African-Americans. Additional research needs to identify treatments for specific illnesses that are being used by college-educated African-American women. Examining these factors will provide even greater insight into the health behaviors of diverse US subpopulations and identify the extent to which barriers to care impact treatment of chronic illnesses.

I also recommend the design of a community initiative to better monitor the health behaviors of African-American women. Because higher SES has not fully eliminated barriers to care before older age, greater attention needs to be given into the complementary and alternative health practices this population. In addition, efforts should be made to present not only present this information to healthcare providers but also bridge the gap between lay and biomedical knowledge and increase trust in the healthcare system. While college-educated African-American women have the health knowledge to understand their illnesses and have greater control over their treatments, African-American women with less education lack this understanding and control. Community initiatives that integrate and monitor usage of biomedical and folk medicine would also help African-American women in other social classes.

I challenge future researchers to further highlight intraethnic variation in the health behaviors, beliefs, and attitudes of African-Americans. They should investigate regional background, ethnic group, and number of generations that have been middle class to further understand the impact of race, culture, and social class on the health behaviors of African-Americans. Research objectives should be expanded to include inquiry into the health behaviors and beliefs of African-American men and cultural dietary patterns. Because poor health behaviors have been documented among Caucasian males, studies including African-American males should separate the impact of gender from that of culture on their health practices. Examining these factors will provide greater information on diverse subpopulations to health providers and hopefully help design more relevant treatment plans that can improve health outcomes for the African-American community.

Concluding Remarks

Health attitudes, beliefs, and behaviors are very complex and are influenced by a number of factors. The purpose of this study was to separate the impact of race, culture, and social class on health behaviors and beliefs through examining intraethnic variation in treatment utilization and healthcare perceptions. This research reveals college-educated African-Americans mainly utilize self-treatment, care from a primary care physician, and prayer/religion for sickness prevention and treatment due to cultural patterning. College-educated African-American reported both greater control over their health care and access to care than African-American women with less education. Despite higher SES, study participants still feared racism and unequal treatment from their provider and exhibited distrust in the healthcare field. However, they still continue to seek care even after experiencing discrimination from a healthcare provider, unlike lower-class African-American women. These findings indicate cultural learning has transmitted medical mistrust and complementary and alternative health behaviors to younger generations, but many of these health behaviors are more characteristic of middle class rather than lower class social status.

It is a great concern that participants aged 20-60 reported limited access to preventative care due to the perceived high cost of care. This is alarming not because it increased reliance on self-treatment among younger generations, but because it suggests higher educational levels and income cannot fully eradicate the health disparities faced by African-American women. I join participants in blaming the structure of our healthcare system for this reality; their criticism of US health care is quite justified. The US government needs to implement a healthcare system that is more open to consider alternatives to biomedical treatments; has more clearly defined insurance plans; offers more practicing minority physicians; is less of a “hassle” to patients; is accessible to all; and bridges the gap between lay and biomedical perceptions of disease and health. Until these measures are met, minority populations will still demonstrate mistrust in the healthcare field and cultural perceptions that physicians cannot effectively treat them.

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Appendix

Questions Posed During Focus Group Discussion[18]

Show Episode Clip from "Unnatural Causes…Is Inequality Making Us Sick?"

- The discussion in this video highlights lifelong discrimination as the main reason middle-class Black women still suffer from poor health outcomes, even when we do everything right: (eat healthy, exercise, avoid cigarettes, do not abuse drugs or alcohol). Do you feel this conclusion is accurate? Why or why not?
    - How do you feel racial discrimination has impacted your own health, the health of your mother, or the health of your grandmothers?
    - Please describe a time you remember when you, your mother or grandmother completely followed a doctor's orders but still had poor health outcomes?

- What other factors can impact the health of college-educated African-American women?
    - How do you feel satisfaction with care can impact the health of college-educated Black women?
        - What are some frustrations or complaints college-educated African-American women have with their healthcare provider or with the healthcare system?
        - Are these complaints related to the race of the physician? Distrust of healthcare system?
    - How do you feel past discrimination from a doctor during a visit can impact the health of college-educated Black women?
        - Can past experiences of discrimination or fear of discrimination affect the doctor-patient relationship?
        - Can past experiences of discrimination or fear of discrimination prevent a college-educated Black woman from sharing all of her concerns and health problems?
    - How do you feel not following physician advice can impact the health of college-educated Black women?
    - How do you feel advice from friends and family about health care, disease, and/or treatment can impact the health of college-educated Black women?
        - Describe a time you remember when the recommendations of family and friends differed from that of your physician?
        - Has the advice your mother has given you about your health different from what your friends have told you? How so
        - Has the advice your grandmother has given you about your health different from what your friends have told you? How so?

- In your opinion, what do you feel causes African-American men to have poor health outcomes as well?

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[18] All leading questions were asked but not all questions bulleted underneath; those questions were provided to give examples of follow-up questions that I could use to obtain more information.

  - Are these the same factors that African-American women face?

- What do you feel can be done to improve your health as college-educated women?
  - Do you believe most college-educated African-American women diagnose themselves and seek care at home before going to see a physician?
  - Do you believe most college-educated African-American women seek health care when needed?
  - Do you believe our health care would improve if we sought more conventional medical care?
    - How much has the cost of healthcare prevented college-educated African-American women from receiving care?

In terms of physician preferences, what race/ethnicity do most college-educated African-American women prefer their physician to be?

  - Does physician race/ethnicity impact the physician a person will choose to see? To what extent?
  - Are there other factors that are more important than physician race/ethnicity?
- How does someone know when he or she should see a physician? How does someone know when to go to the emergency room?
  - What may prevent someone from seeing a physician?
    - Do people fear going to the doctor? Why do they fear seeing a physician?
    - Do people fear what their doctor may say about their health or health problems?
    - What are other fears people have about seeing a health care professional?
    - Do people also not see a doctor because they cannot afford the visit?
  - Describe a situation where someone knows he or she should see a doctor but doesn't go to the hospital?
    - In this case would he or she expect symptoms to go away completely? Would he or she expect symptoms to worsen?
    - Would most people eventually go to see a doctor or bring up the problem in a later visit to the doctor? Or do most continue to deal with the problem on their own?
  - Before seeing a physician do most people self-diagnosis themselves based on their symptoms?
    - If so, do most share this diagnosis with a physician?
  - How do people feel about having to see a doctor about something?
  - Do these feelings ever prevent someone from seeing a physician?
  - Do these feelings affect how someone would view a doctor?
    - Could it make someone feel less or more confident in the care they may receive?

"Comfort" Foods and Cultural Links to Obesity[19]

While greater financial stability has improved the self-reported health status of study participants, it has not caused changes in diet or reduced BMI. This reflects findings in the literature that greater income and educational achievement have not curbed the high rates of overweight and obesity in populations of African-American women. Even though BMI rates of study participants were anticipated to be high, they were not expected to be nearly as high as Table 12 details. The table also includes the national BMI averages of both Black and college-educated BRFSS participants. BRFSS was established in 1984 by the Centers for Disease Control and Prevention (CDC); it currently collects data on health risk behaviors, preventive health practices, and health care access monthly in all fifty states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. BRFSS data are offered in Table 12 to compare the study population with US national populations.

Table 12: Weight Classification by Body Mass Index (BMI) of Study and BRFSS Participants

	Percentages by Research Population		
Weight Classification (BMI)	**Participants in This Study (N=100)**	**Black BRFSS Participants**	**College-Educated BRFSS Participants**
Normal Weight (18.5-24.9)	28 (28%)	27.0%	39.2%

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[19] The remainder of the Appendix will present additional data that was collected that were not a part of my research objectives to obtain.

Overweight (25-29.9)	34 (34%)	33.4%	37.9%
Obese (30 or greater)	38 (38%)	38.7%	22.2%

The weight classification percentages of this study's participants are more similar to those of the black participants from the BRFSS than college-educated participants. Both of these research populations have increasing percentages as weight classification (or BMI) increases. In contrast, as BMI increases for college-educated BRFSS participants, percentages within each weight classification decrease. This seems to indicate that greater educational levels and income have a negligible effect on the BMIs of college-educated African-American women.

Study participants in focus groups highlighted some reasons college-educated African-American women continue to struggle with their weight despite their greater socioeconomic positions. These reasons are primarily due to cultural ties. Firstly, there seems to be resistance to change dietary patterns among elderly African-Americans. A study participant described the food that her family used to eat,

> [My grandmother] would go [to the grocery store down the street] and get vegetables and stuff like that. She also had a garden so she would [get food from it]… but at the same time, we're from the South so the way you cook your food, even though it starts out fresh, it's not gonna always end up as healthy as it could be…When she moved in with us, we were in a better part of town so we technically had access to that [healthier] stuff although we don't partake in it. [Even though] it [the healthier food] was readily available, she still wouldn't have used it because once you get older you're more set in your ways so if you're used to eating a certain way for 60, 70 years of your life, you're not gonna all of a sudden change just because you know some research came out saying you should eat organic food (Participant in the 20-22 age focus group).

The study participant and her family had knowledge of new research detailing healthier eating habits but continued to still utilize cultural ways of preparing food. This quote also highlights scientific research is not enough of a motivator to change diets that have been shaped by culture and practiced for decades. A participant commented,

> Our family history, some of us came from very dire straits financially and they had a lot of days where they couldn't get full. So being able to provide for your family and make them full was a prideful thing because [the attitude is] 'I can feed my kids; My kids don't have to go to bed hungry like I did' (Participant from the ages 40-59 focus group).

Food is not only valued for sustenance but also as a sign of economic security—a more lavish lifestyle. It became culturally acceptable to eat to satiety because there were enough resources to more than meet ones dietary needs. This participants later commented college-educated African-American women continue to struggle with weight because of being forced to overeat by their parents.

African-American Men: The "Uncomfortable" Truth

Every focus group was very vocal about the poor health behaviors of African-American men. Group discussion on this topic generated much discussion and valuable insight. The women had so much to say that one participant in the 40-59 age focus group asked if we would be coming back tomorrow to continue the discussion after I posed the question. Responses in all three focus groups generated the same answers for why African-American men do not go to the doctor: "pride", "stubbornness", "fear", "masculinity". Participants were in agreement that the same factors that prevented African-American women from seeking care also prevented African-American men from seeking care except on a more severe scale. This was discussed by a participant,

> A lot more adamant about not going to the doctor. Not getting tested for stuff, especially prostate cancer. Anything that requires you to be uncomfortable, like colonoscopies. All of which are things that affect African-American men more than other men so all the more reason that they need it but…Like [another participant said,] everything else [that was previously mentioned for African-American women] except on a larger scale (Participant in the 20-22 age focus group).

African-American males are just as reluctant to make changes to their diet as African-American women. One participant shared a fight she had with her husband over switching to wheat bread,

> “My husband has such a significant family history of high blood pressure and diabetes and arthritis and those kinds of things that even … though he was reluctant, the reluctance was expressed to me. But he went. I didn’t have to coerce him or shove him because he saw his parents or his grandparents lose limbs when he was a child and the 4 of them—he’s got 3 siblings—the 4 of them knew that one of them was going to show up with those illnesses, and he’s the one that’s shown up with them. And he’s the one who’s been a real trooper in terms of taking care of himself. Now we did have some in-house fights about changing diet. The biggest argument that we ever had—the children still laugh about it—when I changed from white bread to whole wheat and whole grain, he yelled at me! ‘I want my white loaf bread!’, the kids laugh about that, ‘Right now!’ I took it upon myself at the time that these things started being diagnosed with him to just change the whole family diet. It wasn’t going to hurt anybody to eat in a healthier manner… But he did really good eventually… Well he always did do it, he just had to get his frustration out about it. It was just *me* that he was gonna take it out on. [Group laughs]. But I just decided that he was gonna eat what I cooked or he was gonna cook his own. (inaudible) I just had to set a good example for the children because they might have the same things eventually.” (Participant from the 60-80 age focus group).

In this case, the participant’s husband sought professional medical care even though he was reluctant. He also followed physician recommendations because he did not want to suffer through the same conditions as his relatives. However, this is a rare case. From additional stories that were shared by a participant in the 40-59 age group, the majority of African-

American males delay seeking care until it is too late. Presented below are the two stories she shared:

> I think it is so cultural, across the board, college-educated Black men, older ones, younger ones [delay care] …My father is such an exception because he's really good about all of his doctors and stuff. His best friend, however [was not so good]. His wife to this day is not still angry but she still feels a little bit of bitterness in her heart that if he would've gone to the doctor sooner, they would've caught his prostate cancer sooner [Interjection from the group: "Of course"]. But now [it's], 'You've left me here to raise these two children by myself'. And he was a vet. [He] could go to the VA for free! And wouldn't go to the doctor. Finally he was just laid out sick, couldn't move, and you get to the doctor and [it's], 'You have cancer and it has spread all around.' If he would've gone a few months before… I mean I have a friend who's husband had been telling her he'd been having headaches a lot until the 911 ambulance people called her, 'Uh, excuse me, are you Mrs. Such and Such?' 'Yes.' 'This is the post office. Your husband just passed out and we have the ambulance here about to take him to Grady Hospital.' Because he wouldn't go to the doctor until he literally, Baam! Hit the floor in the middle of the post office and she said she said, 'Can I speak to him for a minute? (pause) Hey, did you mail the mortgage before you fell?' [laughter from the focus group]. Because she said she was so tired of trying to fuss at him and fuss at him and fuss at him about going to the doctor, 'You're still smoking. You know you have high blood pressure.' Blah, blah, blah, blah, blah. And it took a scare like that, that had him laid up in Grady in the emergency room for him to say, 'Okay I gotta do better.' And she said, 'We're not arguing about this because I'm not gonna stress myself out and get my blood pressure up because you won't (pause). I'll just make sure the life insurance is paid up, so if anything happens, the kids will have money to go to college. I'll pay house off and we'll put flowers on your grave every now and then (Participant aged 40-59).

Although the response to the second story was laughter, this undercuts the severity of the problem. This presents a much larger dilemma because the problem demonstrated by these stories is that there is still a reluctance to seek medical care among African-American men, even when access and cost are not an issue. The participant cites the nature of African-American male culture as the reason for these health behaviors among African-American men—a valid assessment. Another participant discussed the unknown origin of the health behaviors of African-American men,

> I don't know if something has happened to them when they were younger. If they had some type of experience that, you know, made it, you know, bad for them as they grew older, but I have two sons and, they're grown, and I say, 'You need to go to the doctor. Don't wait.' I have a brother and I don't know when he's gone to the doctor. And it's not like he didn't have an example of parents that went to the doctor. I went to the doctor, you know, so I don't know what happened. I know with my youngest son, he had a traumatic experience …[when] he was about 3 or 4 he had pneumonia and we took him to the pediatrician and they gave him a shot and he was a little thing. It took 4 or 5 adults to hold him down—he was that afraid of a shot. And he was sick, he had a cold, and I told him, 'You need to go to the doctor, you don't need to wait'. And so when he got to a point where he couldn't talk; he couldn't breathe; he went on to the doctor. But I just think, they're afraid. (Participant from the 40-59 age focus group).

It is interesting that children with parents who utilized biomedical care frequently do not always adapt these behaviors but rely more on self-treatment. These children fall into patterns of not seeking care until it is life-threatening.

Protecting Their Masculinity

One of the reasons African-American males delay seeking care until they have a life-threatening illness is to protect their masculinity. One participant describes the health behaviors of male relatives,

> I watched my father. I watched my uncle … stuff would ail him [my father[and he would take a couple of aspirin and say, 'Well I'll keep it movin' and until he's flat on his back talking about [participant groans], then he's finally gonna go to the doctor. We've finally gotten him to the point where a couple of weeks of, 'Your foot has been bothering you. You might wanna go figure out what's wrong with it.' … [But he responds,] 'I'll just pray. I'll just [suck it up and] … go through it… I think that [this is the case]… especially if they, men, feel like they have to be the providers, 'Because that means if I go to the doctor and I'm out, then I'm not working and I'm not providing and I'm not doing my thing'." (Participant from the 40-59 age group).

African-American men delay care until it is life-threatening because they do not want to be out of work and become unable to provide for their family. It seems almost contradictory that this is such a prominent attitude because seeking care earlier can ensure that they are able to provide for their families longer. Another participant commented on the image of a black man seeking health care,

> I think their [African-American males] idea of health care needs to change. It's …not that they're not getting the attention because the tests are out there. They know what they need to concentrate on. It's just the idea that… they're losing some aspect of masculinity or African-American masculinity by going to the doctor. So whether they have some more prominent examples of Black men that seek health care, or whatever needs to be done... But I think it's in the concept of what they feel, or how they feel they're gonna be viewed as a Black man that goes to the doctor often or regularly. (Participant aged 20-22).

African-American have put their masculinity above their health with immense consequences. Another participant in the 40-60 age focus group discussed the poor health behaviors of African-American men, "I'll say this mostly because it comes to, 'I'm the breadwinner. I'm the head. I don't have to do that. I am in charge and I don't need that… I'm healthy. I'm okay… I'm a man. I don't have to go.'" African-American men often do not seek health care because they do not think it is for them ("I don't have to do that", "I don't need that", "I'm a man"). It is culturally acceptable for them to delay seeking care because seeking care would breach their manhood by causing them to admit they cannot provide for themselves in a given area. Seeking health care is viewed as being acceptable for other members of the family, but not the "head" of the household.

A Low Threshold for Pain and Discomfort

Even though African-American men go to great lengths to preserve their masculinity in the face of African-American men, their efforts have not always been successful. The participants in the 40-59 age focus group joked that African-American men are often some of the worst patients, “And then they’re horrible because if they get sick, even for something minor, they fall apart”. Another participant commented, “Women … have to suck it up! [Agreement from the group]. We’ve been doing this for years! [Directed towards men,] ‘We do it for 9 months of pregnancy, suck it up! Just one time a year, that’s all I’m asking.’” (40-59 age focus group). Another participant even posed to the group, “Imagine if men had to give birth. [Response from another participant] ‘Oh, Lord.’ [Another participant] ‘Everything would change!’ There would be a perfect birth control with no side effects… There would be support for abortion… Not a problem…It’s in the water [the birth control], ‘Drink this.’”

These comments offer another explanation for why African-American men delay seeking care: they wish to avoid the pain and discomfort of some medical procedures. A participant from the 20-39 age focus group commented,

> “[African-American men] are a lot more adamant about not going to the doctor, [about] not getting tested for stuff, especially prostate cancer, [about doing] anything that requires you to be uncomfortable, like colonoscopies. All of which are things that affect African-American men more than other men so all the more reason that they need it. (Participant from the 20-22 age focus group).

African-American men do not get the tests they need because they do not like to be uncomfortable. Low preventative health care is part of the reason rates of diseases like prostate cancer are so high in the African-American male population.

African-American Males and Physician Preferences

In addition to discussing their own preferences for race of their physician, focus group participants were also asked to share their thoughts on the preferences of African-American males for same-race physicians. Discussion indicated that race concordance among African-American males could similarly increase trust in a healthcare provider. This was indicated by a participant,

> I think having a Black doctor would help in building trust in between [the physician and patient]. Because that's one of the things that African-American males [have]…they don't trust the doctor. Like at all. They have these conspiracy theories and all kinds of stuff. And I think it would just help if there were someone that they could at least relate to even if on a surface level, even if they just looked like them. Because they know that maybe you have the likelihood of having the same problem that I do. So you maybe would know a little more about that because you're African-American male and you're a doctor (Participant in the 20-22 age focus group).

Because African-American men are least likely to trust their physician, having an African-American physician would be helpful in assuaging them that they would receive adequate care because of a perceived common background. Having the same skin color as their physician could increase the feeling that the provider would be able to relate to the patient and have greater health knowledge of the issues that disproportionately affect African-American males.

As with African-American females, focus group participants agreed that gender also helps improve the care that African-American males receive. As described by a participant in the 20-22 age focus group, "I think that would help more [if African-American male patients saw African-American male physicians]. I mean, I think that if it was an African-American female doctor then that would be a step up from having somebody you can't really relate to our trust at all". While African-American females would help improve trust by having the same skin color as the patient, having both the same skin color and gender was viewed as a better situation. This was supported by another participant,

> Half the reason why they don't go to the doctor is because of the image they're trying to portray to African-American women. So if you're going to a woman for health care, it's like you did not accomplish anything like as far as

> the secrecy of getting help for your health care kind of thing (Participant in the 20-22 age group).

This participant discusses the issue of African-American masculinity within the context of the physician-patient relationship. Because seeking help for sickness is in contrast to an image of masculinity and a sign of weakness, seeking help from a female physician will only continue to emasculate a male due to his dependence on a woman for treatment recommendations. Seeing a male physician may improve the care African-American males receive because there will not be gender inequality or as negative of a perception to seek help.

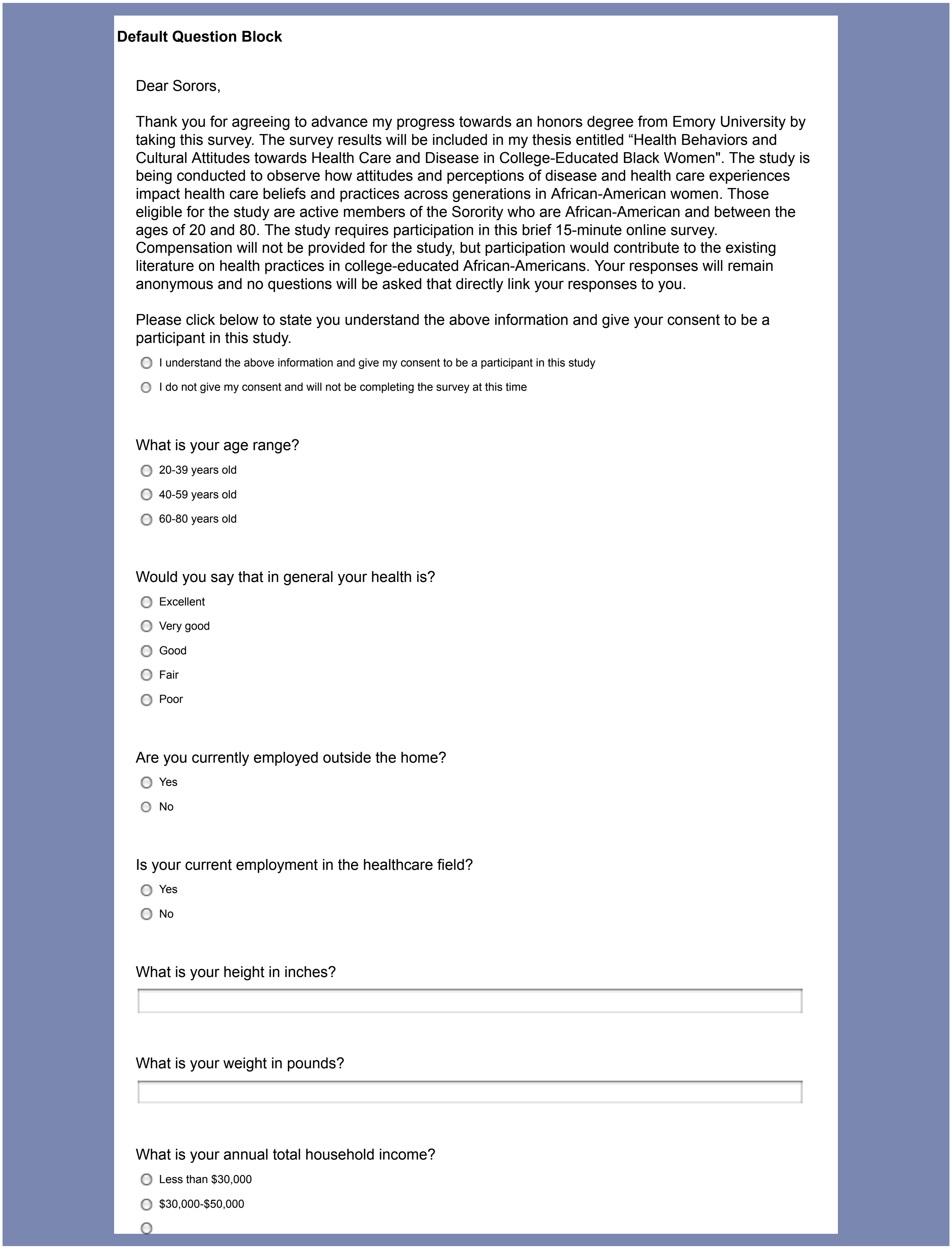
Additional Discussion on the Health Behaviors of African-American Men

Participants were very critical of African-American men for their poor health behaviors. African-American men were described as being very adamant about not going to the doctor due to "pride", "stubbornness", "fear", and "masculinity". It was rare for participants to share positive stories about the health behaviors of their family and friends. Most stories depicted African-American men waiting until it is far too late to seek care; often the first form of care was utilization of the emergency room for a life-threatening sickness. These behaviors were uniform regardless of social class of African-American men, indicating improving social class does not result in greater reliance on biomedical care in African-American men as it does in African-American women. The same generational differences seen in African-American women were also present among African-American men. One participant in the 40-59 age group indicated that her son did not seek care from a physician as often as she did despite her recommendation that he go. It is not known if the son researched his condition and chose to treat himself based on the information he found or if he did not utilize any treatment method.

These women believed that African-American men do not seek care from a physician in order to protect their masculinity and role as the head of the household. One participant in the 40-59 age focus group indicated that the attitude among African-American men is, “I don’t need [to seek care]…I’m a man”. It is culturally acceptable for African-American men to delay seeking care because seeking care would breach their manhood by causing them to admit they cannot provide for themselves in a given area. Seeking health care is viewed as being acceptable for women and children, but not the head of the household. African-American men also delay care until it is life-threatening because they do not want to be out of work or become unable to provide for their family. To do this would also mean a deviance from their responsibilities as the head of their household. It is devastating for disease outcomes that care is not sought until it is often too late. African-American women recommended interventions that would make it acceptable for African-American to seek care are necessary to improve the health behaviors of this subpopulation.

In addition, having an African-American physician may lead to greater trust in one’s physician. This is especially the case with African-American males. Focus group participants felt racial concordance could help increase willingness to seek care and share information with their physician if the physician was Black. Having a same-race physician would be helpful in assuaging African-American males that they would receive adequate care because of a perceived common background, ability to relate to the patient, and a strong health knowledge of the issues that disproportionately affect African-American males.

Additional research needs to generate successful intervention programs to increase reliance on biomedical care by African-American men. In addition, this research should examine the impact of gender and culture on their health behaviors. Until it is culturally acceptable for them to seek care from a physician, African-American males will continue to have poor health outcomes.



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Dear Sorors,

Thank you for agreeing to advance my progress towards an honors degree from Emory University by taking this survey. The survey results will be included in my thesis entitled “Health Behaviors and Cultural Attitudes towards Health Care and Disease in College-Educated Black Women". The study is being conducted to observe how attitudes and perceptions of disease and health care experiences impact health care beliefs and practices across generations in African-American women. Those eligible for the study are active members of the Sorority who are African-American and between the ages of 20 and 80. The study requires participation in this brief 15-minute online survey. Compensation will not be provided for the study, but participation would contribute to the existing literature on health practices in college-educated African-Americans. Your responses will remain anonymous and no questions will be asked that directly link your responses to you.

Please click below to state you understand the above information and give your consent to be a participant in this study.

○ I understand the above information and give my consent to be a participant in this study

○ I do not give my consent and will not be completing the survey at this time

What is your age range?

○ 20-39 years old

○ 40-59 years old

○ 60-80 years old

Would you say that in general your health is?

○ Excellent

○ Very good

○ Good

○ Fair

○ Poor

Are you currently employed outside the home?

○ Yes

○ No

Is your current employment in the healthcare field?

○ Yes

○ No

What is your height in inches?

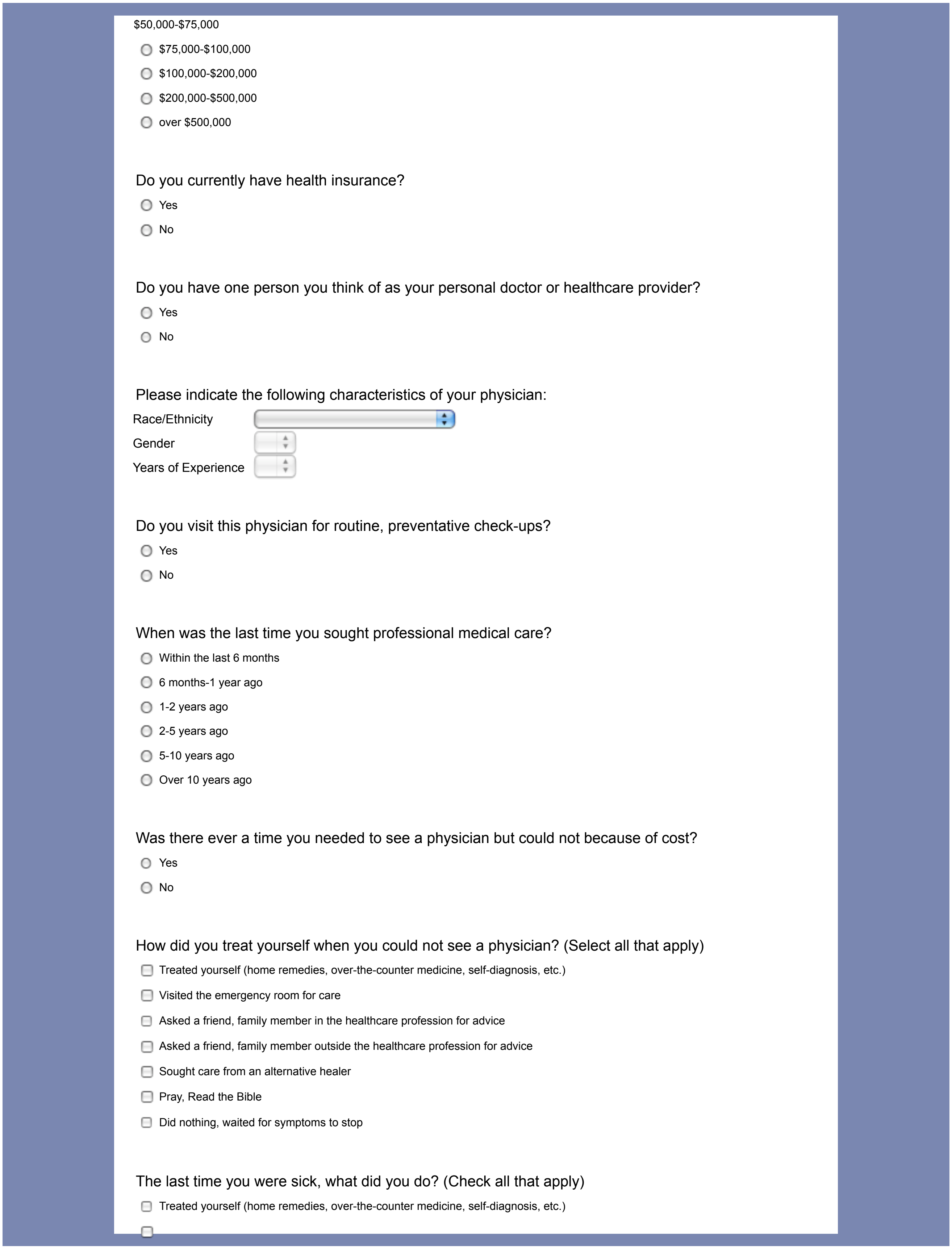
What is your weight in pounds?

What is your annual total household income?

○ Less than $30,000

○ $30,000-$50,000

○



$50,000-$75,000

○ $75,000-$100,000

○ $100,000-$200,000

○ $200,000-$500,000

○ over $500,000

Do you currently have health insurance?

○ Yes

○ No

Do you have one person you think of as your personal doctor or healthcare provider?

○ Yes

○ No

Please indicate the following characteristics of your physician:

Race/Ethnicity

Gender

Years of Experience

Do you visit this physician for routine, preventative check-ups?

○ Yes

○ No

When was the last time you sought professional medical care?

○ Within the last 6 months

○ 6 months-1 year ago

○ 1-2 years ago

○ 2-5 years ago

○ 5-10 years ago

○ Over 10 years ago

Was there ever a time you needed to see a physician but could not because of cost?

○ Yes

○ No

How did you treat yourself when you could not see a physician? (Select all that apply)

☐ Treated yourself (home remedies, over-the-counter medicine, self-diagnosis, etc.)

☐ Visited the emergency room for care

☐ Asked a friend, family member in the healthcare profession for advice

☐ Asked a friend, family member outside the healthcare profession for advice

☐ Sought care from an alternative healer

☐ Pray, Read the Bible

☐ Did nothing, waited for symptoms to stop

The last time you were sick, what did you do? (Check all that apply)

☐ Treated yourself (home remedies, over-the-counter medicine, self-diagnosis, etc.)

☐

Visited the emergency room for care

☐ Visited general practioner for care

☐ Asked a friend, family member outside the healthcare profession for advice

☐ Asked a friend, family member in the healthcare profession for advice

☐ Pray, Read the Bible

☐ Did nothing, waited for symptoms to stop

When your parents felt sick, what did they do? (Check all that apply)

☐ Treated yourself (home remedies, over-the-counter medicine, self-diagnosis, etc.)

☐ Visited the emergency room for care

☐ Visited general practioner for care

☐ Asked a friend, family member outside the healthcare profession for advice

☐ Asked a friend, family member in the healthcare profession for advice

☐ Pray, Read the Bible

☐ Did nothing, waited for symptoms to stop

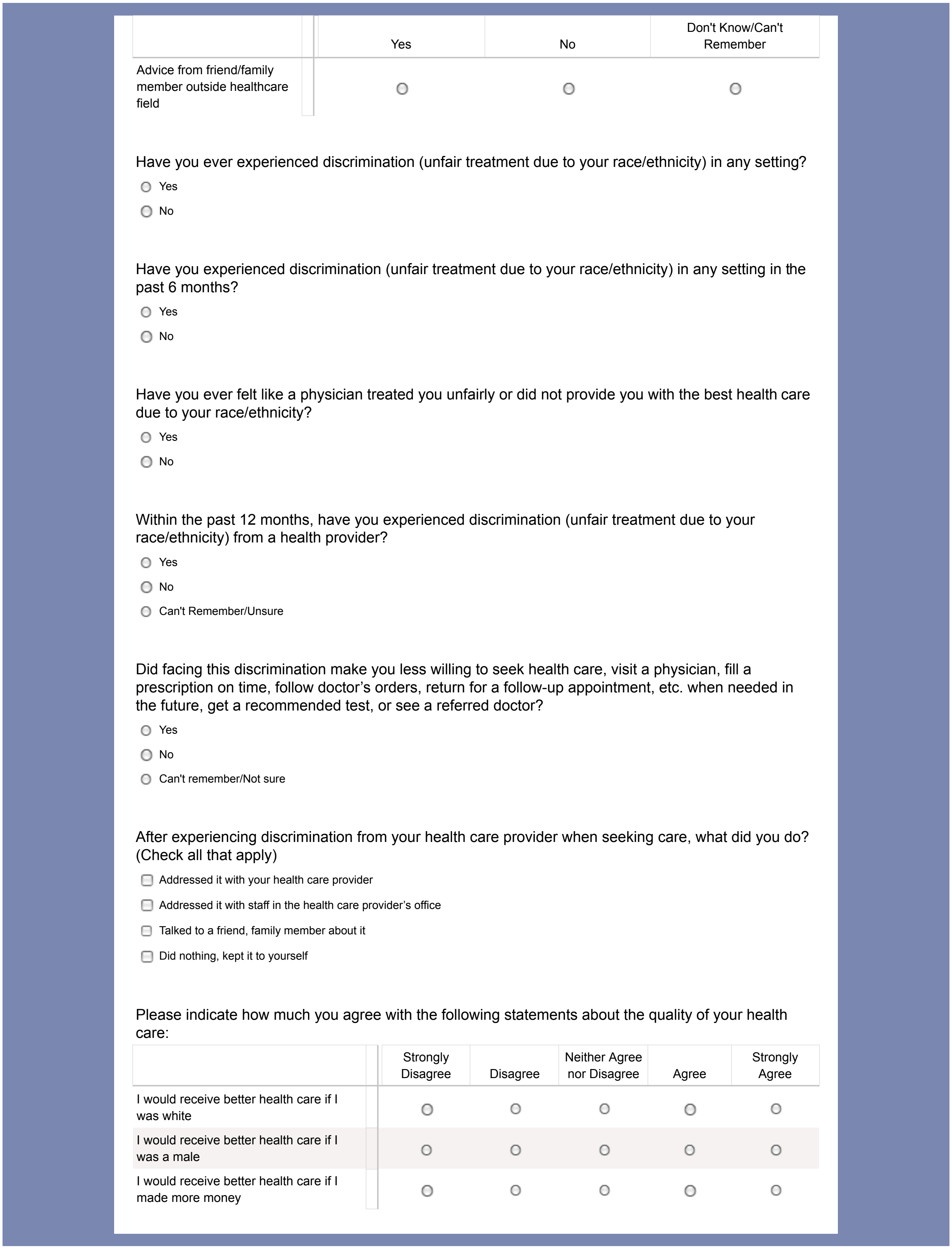
☐ Don't Know/Can't Remember

Have you used any of the following to prevent or treat sickness?

	Yes	No	Not Sure/Can't Remember
Traditional, or home remedies	○	○	○
Herbal remedies, Vitamin therapy	○	○	○
Prayer, Reading the Bible	○	○	○
Consulting a psychic	○	○	○
Consulting a religious leader (pastor, priest, etc.)	○	○	○
Consulting a non-church-based spiritual healer (curandero, voodoo, mystic, shaman)	○	○	○
Over-the-counter medicine	○	○	○
Advice from friend/family member in healthcare field	○	○	○
Advice from friend/family member outside healthcare field	○	○	○

Have you ever used any of the following to substitute for conventional medical care?

	Yes	No	Don't Know/Can't Remember
Traditional, or home remedies	○	○	○
Herbal remedies, Vitamin therapy	○	○	○
Prayer, Reading the Bible	○	○	○
Consulting a psychic	○	○	○
Consulting a religious leader (pastor, priest, etc.)	○	○	○
Consulting a non-church-based spiritual healer (curandero, voodoo, mystic, shaman)	○	○	○
Over-the-counter medicine	○	○	○
Advice from friend/family member in healthcare field	○	○	○



	Yes	No	Don't Know/Can't Remember
Advice from friend/family member outside healthcare field	○	○	○

Have you ever experienced discrimination (unfair treatment due to your race/ethnicity) in any setting?

○ Yes

○ No

Have you experienced discrimination (unfair treatment due to your race/ethnicity) in any setting in the past 6 months?

○ Yes

○ No

Have you ever felt like a physician treated you unfairly or did not provide you with the best health care due to your race/ethnicity?

○ Yes

○ No

Within the past 12 months, have you experienced discrimination (unfair treatment due to your race/ethnicity) from a health provider?

○ Yes

○ No

○ Can't Remember/Unsure

Did facing this discrimination make you less willing to seek health care, visit a physician, fill a prescription on time, follow doctor's orders, return for a follow-up appointment, etc. when needed in the future, get a recommended test, or see a referred doctor?

○ Yes

○ No

○ Can't remember/Not sure

After experiencing discrimination from your health care provider when seeking care, what did you do? (Check all that apply)

☐ Addressed it with your health care provider

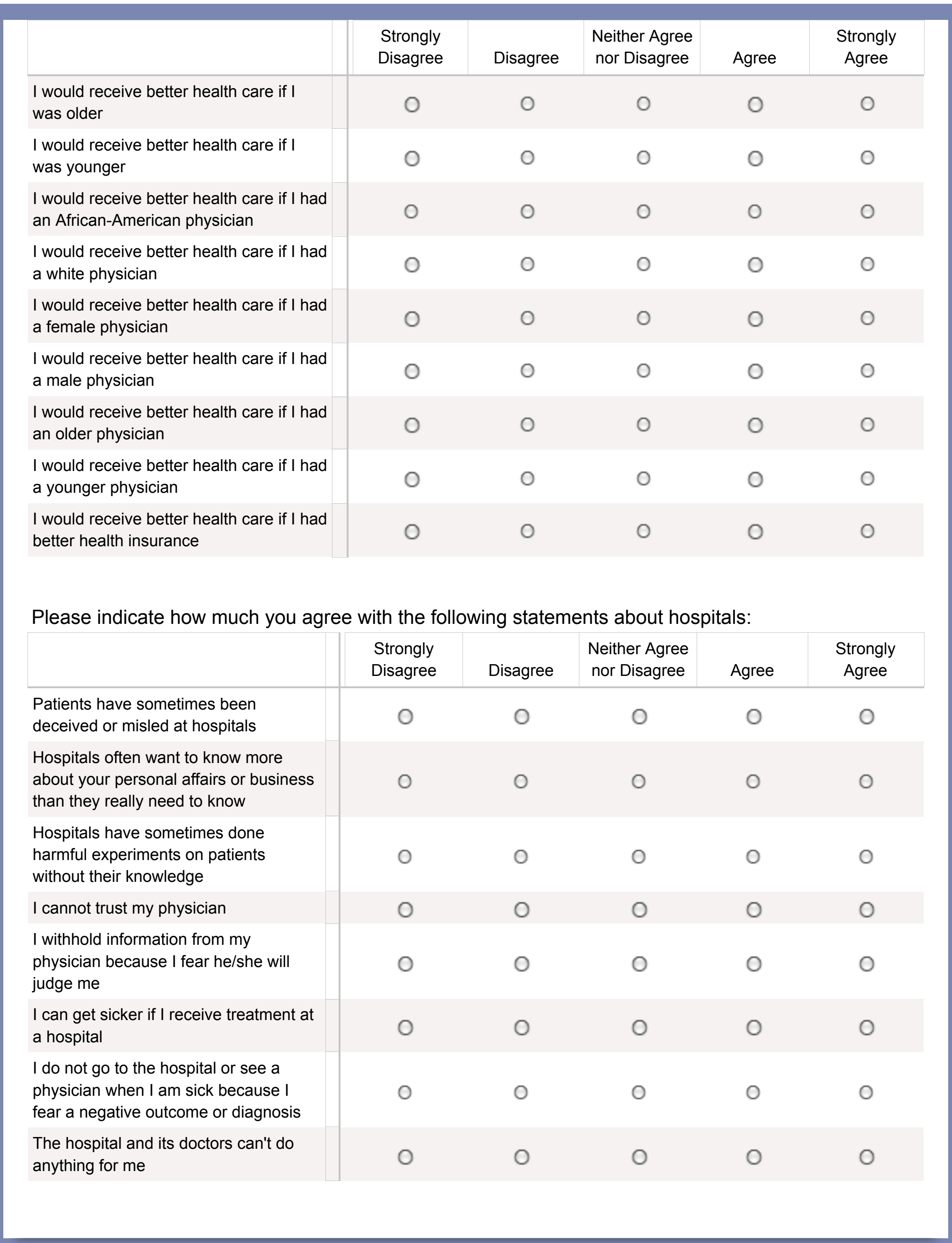
☐ Addressed it with staff in the health care provider's office

☐ Talked to a friend, family member about it

☐ Did nothing, kept it to yourself

Please indicate how much you agree with the following statements about the quality of your health care:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I would receive better health care if I was white	○	○	○	○	○
I would receive better health care if I was a male	○	○	○	○	○
I would receive better health care if I made more money	○	○	○	○	○



	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I would receive better health care if I was older	○	○	○	○	○
I would receive better health care if I was younger	○	○	○	○	○
I would receive better health care if I had an African-American physician	○	○	○	○	○
I would receive better health care if I had a white physician	○	○	○	○	○
I would receive better health care if I had a female physician	○	○	○	○	○
I would receive better health care if I had a male physician	○	○	○	○	○
I would receive better health care if I had an older physician	○	○	○	○	○
I would receive better health care if I had a younger physician	○	○	○	○	○
I would receive better health care if I had better health insurance	○	○	○	○	○

Please indicate how much you agree with the following statements about hospitals:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Patients have sometimes been deceived or misled at hospitals	○	○	○	○	○
Hospitals often want to know more about your personal affairs or business than they really need to know	○	○	○	○	○
Hospitals have sometimes done harmful experiments on patients without their knowledge	○	○	○	○	○
I cannot trust my physician	○	○	○	○	○
I withhold information from my physician because I fear he/she will judge me	○	○	○	○	○
I can get sicker if I receive treatment at a hospital	○	○	○	○	○
I do not go to the hospital or see a physician when I am sick because I fear a negative outcome or diagnosis	○	○	○	○	○
The hospital and its doctors can't do anything for me	○	○	○	○	○