

A PHENOMENOLOGICAL STUDY WITH AFRICAN AMERICAN MALE
CARDIAC PEER SUPPORT VOLUNTEERS

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DEDICATION

This dissertation is dedicated to all African American men and their families who have suffered in silence with cardiovascular disease and a testament to the peer support volunteers that support them.

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For God is working in you, giving you the desire and the power to do what pleases Him. — Philippians 2:13. May I continue to be guided by His plans that He has for me. May I continue to make full use of the angels that He continues to bless me with. This dissertation reflects the efforts of the numerous people who supported guided sacrificed and funded me over the past eight years.

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ABSTRACT

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A PHENOMENOLOGICAL STUDY WITH AFRICAN AMERICAN MALE CARDIAC PEER SUPPORT VOLUNTEERS

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This qualitative phenomenological study was designed to focus on the lived experiences of African American male cardiovascular peer support volunteers (AAMCPSV) within a healthcare setting. There is a paucity of African American male peer support volunteers to work with the increasing numbers of African American cardiovascular patients. The scarcity of AAMCPSV warrants the question of factors contributing to the lack of organizational policies, challenges faced within hospital staff, and lessons learned from the few males who have been peer support volunteers in the past five years. The purpose of the study was to explore the lived experiences of AAMCPSV with a goal of understanding the phenomena from their perspectives. This research was guided by one overarching research question: What are the lived experiences of African American male cardiac peer support volunteers in a healthcare setting? The findings of this study from the perspectives of the AAMCPSV are that the African American peer support volunteer is the most capable member of the healthcare team to help guide the cardiac patient and family out of the crisis; volunteering to the African American patient improves the cardiac health of the volunteer and the patient;

masculinity and sexuality are underlying and under recognized concerns; and the AAMCPSV want to empower other African American males to join the cause.

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CHAPTER I

INTRODUCTION

African Americans are more likely than any other ethnic group to have poorer health, cardiovascular disease, and post-cardiac surgery morbidity (Centers for Disease Control and Prevention [CDC], 2017; Guy-Walls & Long, 2017). Despite advancements in healthcare that have improved survival, over 610,000 persons die annually from heart disease (Benjamin et al., 2018; CDC, 2017). According to the CDC (2017), nearly half of all non-Hispanic Black adults (47% female, 46% male) have some form of cardiovascular disease. Studies show that African Americans continue to be at a significant disadvantage when it comes to post-surgical care because they suffer a 50% higher rate of death in post-surgery than the general population (Benjamin et al., 2018; Khera, Vaughan-Sarrazin, Rosenthal, & Girotra, 2015; Lukachko, Hatzebbuehler, & Keyes, 2014).

A vital member of the post-surgical care team is a volunteer peer support person who helps the patient understand the lifestyle changes they must make in order to survive the cardiac event (Parry & Watt-Watson, 2009). Moreover, the peer support volunteer establishes a trust bond based on the shared medical experiences as well as being of the same race and gender (Barg, Weiner, Joseph, Pandit, & Turner, 2012). Studies show that having this relationship with a trusted volunteer increases the likelihood that the patient will comply with the recovery recommendations of the healthcare team (Heisler, 2009). The critical shortage of African American male cardiac peer support volunteers

(AAMCPSV) may decrease the effectiveness of this model in male African American cardiovascular disease patients, thereby increasing the risk of post-surgical death (Jackson & Parks, 1997; Kennedy, Mathis, & Woods, 2007; Shelton et al., 2016).

In response, the federal government began supporting health programs that employed community volunteers as sources of advice, information, and support (Arvey & Fernandez, 2012; Mensah et al., 2018). Research on cardiovascular disease has shown that since the 1950s, volunteer workers have been used to assist cardiac patients within the cardiovascular health delivery system (Barg et al., 2012; Fisher et al., 2017; Mended Hearts, 2019). Studies show that since the 1960s, the roles and responsibilities of volunteer health worker programs have evolved to support chronic disease patients (Burr, Han, Lee, Tavares, & Mutchler, 2018; Krantz et al., 2013; Parry & Watt-Watson, 2009 ; Willock, Mayberry, Yan, & Daniels, 2015). A critical component of the after care for patients involves peer support volunteers who work with the cardiac team. Peer support volunteers are often members of the target population who are well positioned to help the patient overcome social, lifestyle, and cultural barriers that occur during the healing process (Mangla et al., 2018). Furthermore, providing support to others can lead to improved health behaviors on the part of the helper, decreased mortality risk, and improved patient health outcomes and functioning (Burr et al., 2018).

African Americans suffer from heart disease at a disproportionate rate in comparison to other racial/ethnic groups (Benjamin et al., 2018; CDC, 2017). Despite progress made in the medical field, this population continues to be at a significant disadvantage when it comes to the aftercare following cardiac surgery (Benjamin et al.,

2018; CDC, 2017; Fisher et al., 2017). Using a meta-analysis, Berkman, Leo-Summers, and Horwitz (1992) found a direct link between social isolation and increased mortality among patients. Higher levels of social support, especially illness-specific or regimen-specific support are associated with better illness self-management (Dubbin, McLemore, & Shim, 2017; Fisher et al., 2017; Turner et al., 2012). Moreover, observational studies suggest that volunteers who provide social support to others may experience positive health benefits which include heightened self-esteem, reduced depression, and improved quality of life, even after adjusting for baseline health and socioeconomic status (Burr et al., 2018; Long, Ponder, & Bernard, 2017). Peer support mentoring has been shown to be especially effective with non-White individuals who have a historic, cultural mistrust of the predominantly White healthcare system (Barg et al., 2012; Shim, 2005). This dissertation was focused on understanding the lived experiences of African American male peer support volunteers.

Study Significance

The gap in life expectancy between African Americans and the general population is driven primarily by excess cardiovascular disease mortality in African Americans American Heart Association [AHA], 2018). While African Americans are overrepresented in the prevalence of conditions such as cardiovascular disease and stroke, they are grossly underrepresented in the studies to improve aftercare following cardiac surgery (CDC, 2016). Research shows there is a critical shortage of African American male peer support volunteers, which may negatively affect health care outcomes for cardiovascular patients overall (Bailey, Krieger, Agénor, Graves, Linos, & Bassett,

2017). Research has not yet identified credible strategies to recruit and retain African Americans into peer support cardiovascular volunteer positions trained within healthcare settings (Hall et al., 2016; Sokol & Fisher, 2016). This study is significant because the results of the findings contributed to the literature on cardiovascular peer support volunteerism. This study is also significant because it gave healthcare providers a better understanding of the perspectives of African Americans males who work with cardiovascular patients in a healthcare setting. Healthcare providers can take the results of this study and develop policies and strategies to recruit and retain AAMCPSV. Finally, this study is important to the field of Family Sciences as there is currently a narrow bridge to resolve the shortage of African American male peer support volunteers (Kennedy et al., 2007). This study may help family scientists understanding of family resilience in the face of a health crisis. The results may share knowledge to assist with volunteer healthcare organizational strategies.

Statement of the Problem

There is a dearth of literature on African American peer support volunteer health workers (Barg et al., 2012). During this century, research on this topic has focused more on causes and barriers that can be attributed to women and mainstream groups, not on particular cultural barriers, that may adversely affect volunteerism among African American male peer support volunteers (Carter & Marx, 2016; Marx, 2000). While the barriers for male peer support volunteers, both Black American and White American may be similar, there may also be unique factors that affect the persistence and tenure of African American peer support volunteers which has not been uncovered in the literature

(Barg et al., 2012). To this end, this study uses phenomenology to explore the lived experiences of African American male peer support volunteers who work in a healthcare setting.

Statement of Purpose

The purpose of this phenomenological study was to focus on the perceptions, experiences, and emotions of African American male cardiac peer support volunteers who worked with a healthcare team to administer care to cardiac patients in a healthcare setting. This researcher asked AAMCPSVs how they inspired cardiac patients; how serving impacted their lives; how they connected with the male African American patients; and their recommendations for the healthcare community. This study also focused on beliefs African American men have about cardiovascular disease, mistrust of the medical community, and how the African American peer support volunteer was able to ferret out the information. Lastly, this study sought to understand how the African American peer support volunteer survived in an unsupported environment.

Understanding what constitutes successful volunteering for minorities, especially for African Americans, may help guide future recruitment promotions of minorities into volunteer roles, particularly African American males serving as cardiac peer support volunteers. This understanding would add to the existing perceptions, meanings, and definitions of peer support volunteerism. Ultimately, knowing how best to recruit, develop, and retain volunteers among African American men would be a benefit to their families, the healthcare teams, and family sciences professionals.

Theoretical Framework

The theoretical frameworks for this research study included the social cognitive theory (SCT) and the health belief model (HBM). Each theory is presented in relation to the exploration of the lived experiences of African American males who work with cardiac patients.

Social Cognitive Theory

Albert Bandura (1986) introduced SCT in 1963, with refinements in 1977. The theory posits that people learn from one another through imitation, observation, and modeling (Bandura, 1986). Central to SCT is the three-way interaction between personal, social environmental, and behavioral factors (Schunk & Usher, 2012). SCT has been used in several projects focusing on African Americans, heart disease, and healthy behaviors, including “The Pine Apple Heart Disease and Stroke Study” (Kuhajda et al., 2006). The application of this theory within these studies was to get patients to adopt belief-based constructs in order to improve their heart health.

In the same manner, the SCT was utilized in this dissertation to improve heart health through the modeling of healthy behaviors by the AAMCPSV. SCT was advanced in this study through the interactions of the African American male peer support volunteers who served as agents of hope to the cardiac patient and their families during the health crisis. Additionally, the participants bonded with the patient on race and gender that allowed them to extrapolate key issues of health information relevant to the patient such as (a) masculinity issues, (b) distrust, and (c) fear that the patient harbored towards

the healthcare team. Due to the limitations of SCT, to totally identify patient influencers of change, an additional construct, the HBM was incorporated (LaMorte, 2018).

Health Belief Model

Originating around 1952, the HBM is generally regarded as the beginning of theory-based research in health behavior (Rosenstock, Strecher, and Becker 1988). The HBM has been used to explain and predict a wide range of health behaviors. The tenets of HBM identify a person's motivation to undertake a health promoting behavior based upon their understanding of the severity of their health problems, the perceived benefits and barriers to acting on those concerns, and a cue to action (Jones et al., 2014).

The researcher operationalized the HBM by a male African American advocate of health who survived a cardiac incident. This person becomes a volunteer in a healthcare setting to help other people in his community who are experiencing a heart health crisis. After receiving training, the volunteer is linked to a healthcare team.

Theoretically, the volunteer is the extended layperson of the community helping the patient understand the health crisis and the changes required to survive. Additionally, the volunteer has been used to reinforce the recovery regime of the physicians and nursing staff. In this study, the volunteer emerged as an essential vessel of change for the patient. Due to the volunteers' previous experiences with heart disease and related socioeconomic factors they were able to bond with the patient and family. Thereby, the volunteer was essential for helping the patient navigate the healthy behaviors necessary to survive the crisis.

Research Question

In order to gain a better understanding of the issues facing African American male peer support volunteers who support cardiac patients, the following question guided this study:

What are the lived experiences of African American male cardiac peer support volunteers in a healthcare setting?

Assumptions

According to Leedy and Ormrod (2010), assumptions in qualitative research are beliefs that are found to be true or taken for granted. Listing the assumptions may help transference of research study findings (Saldaña, 2013). This research study was based on several assumptions. The first assumption was that African American male peer support volunteers would respond truthfully and accurately to the interview questions. Second, the researcher would actively engage the participants of the study (Leedy & Ormrod, 2010). The final assumption was that inferences were taken from truthful responses.

Delimitations

Delimitations are the restrictions or boundaries set by the researcher of the study, which narrow the scope (Leedy & Ormrod, (2010). This study was limited to 10 African American male peer support volunteers in a healthcare setting. Therefore, this number may or may not be sufficient to understand the phenomenon from the perspective of the participant. The findings cannot be generalized to any other ethnicity, or to any other locality. Providing a participant with an estimated timeframe may cause a preconceived notion on how long the participant is able to express their views and ideas. Thus a 60 -

90-minute timeframe for the interviews may be a delimitation for the participant (Leedy & Ormrod, 2010).

Definition of Terms

1. African American may be used interchangeably with Black, Colored, or Negro to refer to a person having origins in any of the Black racial groups of Africa (U.S. Census Bureau, 2018).
2. Cardiac peer support volunteer is an African American male who has experienced a heart incident then becomes a trained volunteer on a cardiac healthcare team serving as the liaison between the African American patient and the healthcare team (AHA, 2018; Mended Hearts, 2019).
3. Caucasian/White is a person having origins in any of the original peoples of Europe, the Middle East, or North Africa (U.S. Census Bureau, 2018).
4. Healthcare setting refers to settings where the patient, medical providers, and volunteers interact to receive or provide service.
5. Heart disease describes a range of conditions that affect the heart is often used interchangeably with the term *cardiovascular disease* (Mayo Clinic, 2018).

The Researcher as a Person

Living a healthy lifestyle has always been a general focus for the researcher. It was not until a 2012 diagnosis of cardiovascular disease and subsequent open-heart surgery that the researcher began to fully appreciate the complexity of living with cardiovascular disease. As a cardiac bypass surgery survivor, this researcher has experienced the full spectrum of what it means to be in recovery and have access to a

trustworthy, knowledgeable person who properly guides them to the lifestyle changes necessary for survival. Additionally, this researcher witnessed what can happen when a patient does not have exposure to quality post-surgical care.

As a peer support volunteer, the researcher has experienced the fulfillment that comes from helping another person through the recovery process from heart surgery. Thus, the catalysts for this dissertation were the experiences, both positive and negative, in addition to the limitations experienced in the role of an African American male peer support volunteer, working with cardiac patients. There were many instances where the healthcare team, hospital policies, and hospital procedures were out of sync with the extended needs of the patients to have care that addressed their needs outside of their illness, such as the individual, family, and social challenges.

Summary

In review, there is an increasing public health concern (AHA, 2018) about the need for African American male peer support volunteers to care for the increasing numbers of African American male cardiac patients (Kennedy et al., 2007). The reciprocal nature of SCT and the health promotions identified in the HBM provided a lens to view the interchanges between African American cardiac male peer support volunteers and the patients they cared for (Bandura, 1986; Rosenstock et al., 1988). Although peer support volunteerism has been around for decades, the phenomenon of the African American male peer support volunteer has not been rectified in the literature. In the next chapter, a thorough review of the literature surrounding the problem will be discussed.

CHAPTER II

LITERATURE REVIEW

African Americans have a dichotomous history of participation in social change and public health (Kennedy et al., 2007). First, there is a long tradition of involvement in social change and social justice movements. Through their voluntary participation in civil rights organizations, service guilds, and church-based organizations, many African Americans have worked both to critique and radically alter unjust social and economic conditions (Billingsley & Caldwell, 1991). Conversely, African Americans have viewed participation in the medical research community with extreme mistrust. From the antebellum period where Black slaves and free African Americans were unwilling participants to human experimentation and dissection, continuing to the Tuskegee Syphilis Study, the medical community has cultivated a legacy of fear and mistrust within the African American community (Gamble, 1997; Kennedy et al., 2007). While there is a substantial body of empirical literature on volunteerism and social participation in the general population, little to no literature has focused on African American volunteerism in cardiovascular health. The relative silence surrounding African American volunteerism participation exists in tandem with an urgent call for increased numbers of peer support volunteers.

This chapter focuses on three key areas. The first section offers a historical and cultural perspective on peer support volunteers. The next section addresses the social

support aspects of peer support volunteerism. The final section identifies the unique characteristics of the African American volunteers. This literature review includes scientific peer-reviewed articles from the PubMed.gov database and the Thoreau multiple database containing ProQuest, SAGE, Science Direct, and others. The Thoreau multiple database and the Medline database were accessed through the Texas Woman's University library. Keywords used to find articles related to this topic included history of volunteer health workers, heart disease, African Americans, cardiovascular disease, social support, community health workers, and social network.

Theoretical Perspectives on Volunteerism

Several models of volunteerism have emerged within the Family Sciences literature to guide research on volunteerism and cardiac health. Taken together, these models have been influential in studies of modeling good health, and likewise, inform this particular study of volunteerism to improve African American male cardiac patient care in healthcare settings.

Social Cognitive Theory

In a review of the literature on modeling good health to patients with chronic disease, particularly minority cardiac patients, Albert Bandura (1986) found that through the SCT people learned from one another through imitation, observation, and modeling. Basically, the model (see Figure 2.2) outlined a three-way interaction between the personal, environmental, and behavioral factors during which a patient's behaviors become exposed to these influences (Lee et al., 2017; Schunk & Usher, 2012). Other research that utilized SCT included a study on the effects of a dietary intervention that

lowered blood cholesterol levels and reduced coronary risk. Researchers operationalized that the three components of SCT (personal, social environmental, and behavioral factors) would produce dietary change, affect cholesterol, and reduce coronary heart disease (Carmody et al., 1986). Schunk and Usher (2012) identified four limitations of the SCT when applied to public health; therefore, another theoretical framework was required to totally understand the challenges of the African American peer support volunteer in a healthcare setting (see Figure 2.1).

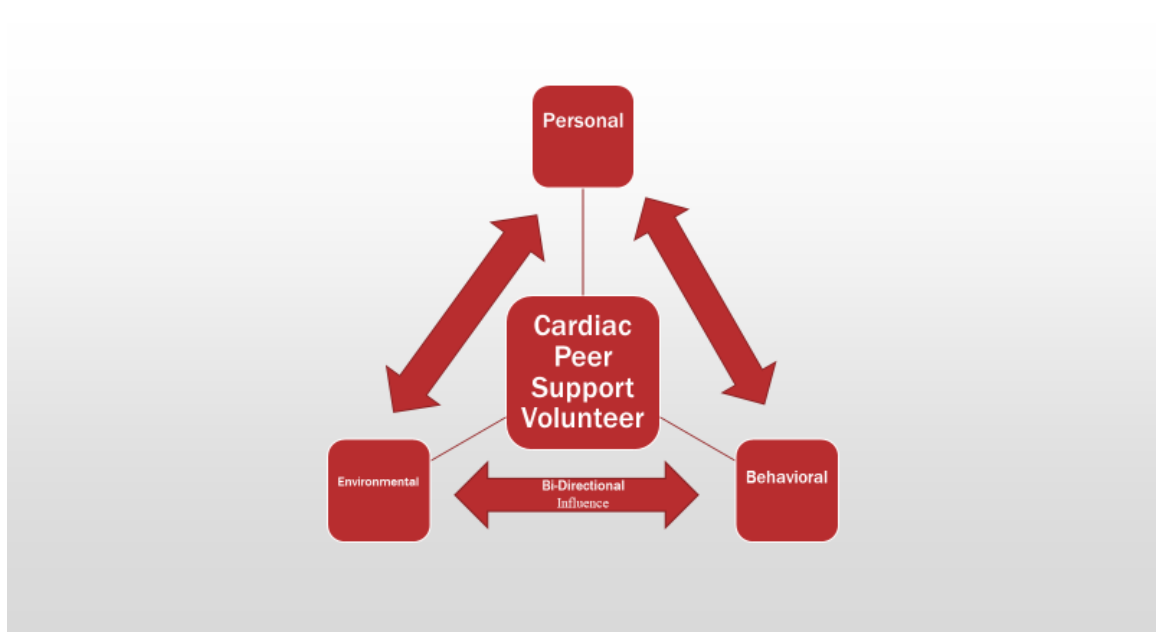


Figure 2.1. Social cognitive model. Adapted from Bandura's social cognitive model.

Health Belief Model

Previous studies that examined health behavior prediction model on chronic disease provide theoretical and empirical guidance. For instance, Rosenstock et al.'s (1988) HBM identifies a person's motivation to undertake a health promoting behavior

based upon their understanding of the severity of their health problems, the perceived benefits and barriers to acting on those concerns, and a cue to action (Jones et al., 2014).

Kuhajda et al. (2006) explored African American men living in the Southeast United States in an area commonly known as the “stroke belt.” Through interviews, Kuhajda, et al. (2006) gleaned that the study participants had a high level of knowledge about self-management of hypertension (a common symptom of heart disease). Further, the barriers to the participant’s self-management included medication side effects and poor diets. The participants also expressed that issues of masculinity and vulnerability related to the diagnosis further reduced their ability for self-control (Long, Ponder, & Benard, 2017). For an overview of the HBM (see Figure 2.2).

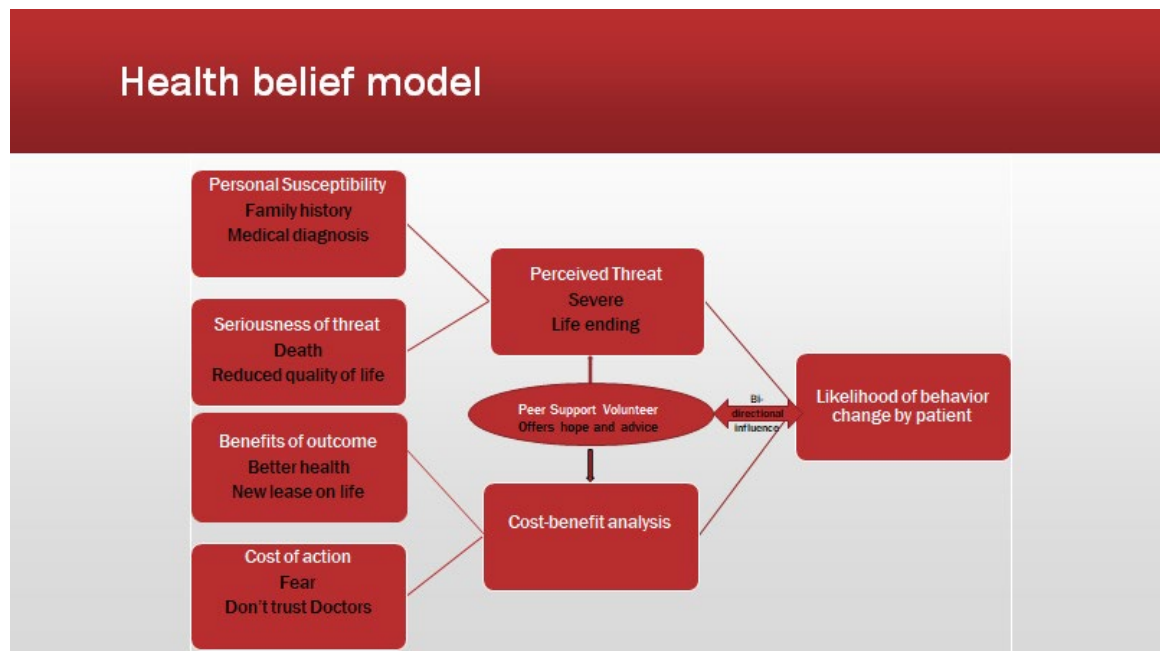


Figure 2.2 Health belief model figure. Adapted from Rosenstock et al. (1988).

History of Peer Volunteer Health Workers

This section is a review of the literature on the history of volunteer community health workers serving in health promotion programs throughout the United States (Arvey & Fernandez, 2012; Berkman et al., 1992; Burr et al., 2018; Krantz et al., 2013; Mensah et al., 2018). While formal participation of volunteer health workers in health and human services programs in the United States has been documented since the 1950s, it was not until the 1960s that the federal government began providing financial support to these programs as vehicles for expanding healthcare to underserved communities (Mensah et al., 2018). Arvey and Fernandez (2012) explored the roles of volunteer health workers in the early 1960s and found that volunteer health workers played a significant role in rural programs in many developing countries. The workers promoted literacy, family planning, immunization, and other economic development activities (Arvey & Fernandez, 2012). In the 1970s, community health workers were increasingly recognized for their use of social relationships to improve patient health, particularly in rural and isolated populations (Burr et al., 2018). Berkman et al. (1992) found that many of the program evaluations, which emerged in the early 1990s, concluded that volunteer health workers contributed positively to promoting health (Burr et al., 2018; Krantz et al., 2013).

Characteristics, Roles, and Responsibilities of Peer Volunteer Health Workers

The literature within this section defines practices of the general peer volunteer. Rosland et al. (2013) found that peer volunteer health workers are typically from the communities they live in and serve (Rosland et al., 2013). They possess strong leadership

and motivational capabilities (Lee et al., 2017; Rosland et al., 2013). However, within the literature, there was no clear universal definition of a peer volunteer community health worker. The most common definition described volunteer community health workers as individuals who are local, indigenous, residents of underserved communities (Sokal & Fisher, 2016). These volunteers serve as crucial bridges between their community and health care providers to promote health among neighbors who have traditionally lacked access to adequate health care (Sokal & Fisher, 2016).

Willock et al. (2015) explored the literature and found other titles that substituted for the “community health worker” such as promotoras, health promoters, natural helpers, lay health advisors, peer support advisors, community health advisors, and parish nurses. Heisler (2009) found that since lay health advisors have language, ethnicity, religious beliefs and social characteristics in common with the patient, the assumption is that they can promote preventive behaviors more effectively than health professionals, who are normally outside of the patient’s community.

Parry and Watt-Watson (2009) found that many community health workers would argue that they are not paraprofessionals, they are often presented to the patient as semi-professionals, elevating their status in their communities. Sokol and Fisher (2016) posited that the natural lay person is distinguished from a professional by their lack of formal training. Natural lay helpers are given minimal training on intervention delivery techniques.

Natural lay helpers are selected by several methods (AHA, 2018). Heisler (2009) found that natural lay helpers are recognized as community residents who have

distinguished themselves as respected, caring individuals with reputations as credible advice-givers (see Figure 2.3). Eng and Young (1992) found that natural lay helpers are also selected because of their experience with the phenomena of the patient. Once selected, these helpers were given limited training on intervention methods.

Despite numerous studies in the literature that the peer support volunteer can minimize the effects of chronic illnesses like diabetes, cancer, and stroke, very few studies tailored intervention toward heart disease (AHA, 2018; Lee et al., 2017). Nonetheless, within the existing literature, Parry and Watson (2009) found that peer support volunteers produced a positive outcome on individuals with heart disease through a reduction in emergency room visits, greater reduction in pain levels, and increased physical activity.

Lay person	Peer Support	Paraprofessionals
Respected member from the targeted community offering to help	Respected member of the community offering to help, or was selected by the health professionals to support the patient	Generally not a respected member of the community
No formalized training or support network	Share the same experiences conditions and recovery experience as the patient	Most likely have not experienced the same condition as the target population
Generally are non-medical workers	Generally are not professional medical workers	Highly trained medical professional
(Heisler, 2009; Rosland et al., 2013; American Heart Association, 2018)		

Figure. 2.3. Characteristics, roles, and responsibilities of peer volunteer health workers.

Cardiac Peer Support Volunteers

Within this section, the literature will discuss the evolution of the cardiac peer support volunteer as an extension of the general peer support volunteer (AHA, 2018, 2017; Fisher et al., 2015; Kennedy et al., 2007; Lee et al., 2017; Parry & Watt-Watson, 2009; Willock et al., 2015). Research has found that cardiac peer support interventions produce a positive outcome on individuals with heart disease through a reduction in emergency room visits, greater reduction in pain levels, and increased physical activity (AHA, 2018; Lee et al., 2017; Parry & Watt-Watson, 2009).

In the 1940s, Dr. Dwight Harkin, a pioneer of modern heart surgery, was also noted as the originator of the cardiac peer support model (AHA, 2018). Harkin was a Marine Corp Captain serving during World War II and successfully removed foreign bodies from the hearts of hundreds of soldiers wounded in battle. In the post-war years, Harkin continued his research on open heart surgical patients. He recruited four of his healed heart patients to share their experiences and motivate recovering heart patients. Building upon the initial success of the group, further outreaches to the cardiac patient community resulted in the formation of a national organization called Mended Hearts, which subsequently grew into the largest cardiac peer support organization in the United States (Mended Hearts, 2019).

Cardiac peer support volunteerism emerged as an extension of the peer support community health worker that specifically addresses heart health (Mended Hearts, 2019). In this role, the volunteer, who is a person that has heart disease or heart related trauma, receives limited training and joins the healthcare team serving as a liaison between the

patient and the healthcare team. Their credibility emerges from their experience as a heart disease patient. They also understand the patient's challenges with the family and social issues that impact their health (AHA, 2018; Mended Hearts, 2019).

Impact of Social Support on Heart Health by Race / Ethnicity

Shim (2005) explored the literature on the impact of social support on cardiac patients by race/ethnicity and learned that up and through the 1980s, research studies predominantly used Caucasian subjects for the participant pool. As heart disease rates rose in the African American community, African Americans were recruited as participants in studies that examined heart disease. In a search for strategies to improve heart health, researchers explored social support (Dubbin et al., 2017; Lukachko et al., 2014). A general theme in the studies on social support was that it exhibited a positive influence on heart health outcomes, particularly among African Americans (Warren-Findlow & Prohaska, 2008).

Researchers examined the interplay of structural racism and heart attacks among African Americans. Using the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions data set with a total sample population of 32,752 (non-Hispanic Black: $N = 8245$; non-Hispanic White: $N = 24,507$), Lukachko et al. (2014) used four domains to measure for racism (a) political participation, (b) employment and job status, (c) educational attainment, and (d) judicial treatment. The study results found a positive correlation between political participation, educational attainment, employment, and myocardial infarction. The study identified a positive relationship between structural racism and myocardial infarction.

In another study, Dubbin et al. (2017) examined African Americans living with coronary heart disease. The qualitative study used grounded theory to examine the stories of 32 participants ($N = 22$ primary participants, $N = 10$ family members). Of significance, the study found that for the participants, the behaviors that lead to the development of cardiovascular disease were closely tied to their level of social support.

The general theme in these studies was that social support did exhibit a positive influence on heart health outcomes among African Americans. Some benefits associated with social support included improved heart knowledge, improved coping skills, improved compliance with medications, and quicker recovery from myocardial infarction (Rankin & Quane, 2002; Warren-Findlow & Prohaska, 2008).

In the case of African American cardiac patients, positive influence from a strong support system has been shown to contribute to a decrease in cardiac recurrence/hospital readmission (Kennedy et al., 2007; Shim, 2005). In comparison to Caucasians, African American heart health disparities still exist in the areas of self-care, emotional social support, longer hospital stays, and readmission (Lu et al., 2016). Another example of disparity was that of the studies mentioned above, African American study participants were only the majority population in only a few of the studies (Kennedy et al., 2007; Lu et al., 2016; Shim, 2005) listed above and these studies did not assess cardiac recurrence or specific types of social support that may be important to the African American population in battling cardiac illness (Kennedy et al., 2007; Parashar et al., 2012).

The following studies have shown that the infusion of social support during patient recovery has also shown promise in protection against cardiac relapse (Lu et al.,

2016; Thomson, Molloy, & Chung, 2012; Warren-Findlow & Prohaska, 2008). Warren-Findlow and Prohaska (2008) found that social support was deemed to be valuable in the recovery of African American and Caucasian women who had suffered a heart attack (Lu et al., 2016; Warren-Findlow & Prohaska, 2008). Another study that examined African Americans and the role of social support on cardiovascular health was conducted by Thomson et al. (2012). This study examined the effects of social support on self-care (medical adherence, dietary adherence, and heart failure symptom monitoring functions) among African Americans. Thomson et al. (2012) hypothesized that relatively high levels of social support from friends, a significant other, and family members would result in high levels of self-care among heart failure patients.

Researchers further illustrated that social support was associated with improved self-care among heart failure patients (Lu et al., 2016; Parry & Watt-Watson, 2009). Being married was found to be a significant factor in patients adhering to medication protocol (Lu et al., 2016). The positive benefit of marriage was found to be more the case for African Americans than Caucasians, which lends to the suggestion that African Americans have tighter ties (more frequent contact) with kin. Therefore, physicians should be more aware and implement higher levels of social support into the recovery regimen of heart patients (Lu et al., 2016). A significant strength of this study was a large number of African American participants ($N = 611$; Lu et al., 2016).

Social support also proved beneficial in a study conducted by (Aggarwal, Liao, Allegrante, & Mosca, 2010). In this study, Aggarwal et al. (2010) examined the effects of low social support on diet adherence in a cardiovascular disease lifestyle intervention trial

for recovering coronary heart disease patients. Results showed that low social support was positively associated with non-adherence to diet recommendations at one year. Thomson et al. (2012) examined the effects of perceived social support on the quality of life in patients waiting for coronary artery bypass grafting and their partners. These results showed the importance of social support in heart patients taking care of themselves and maximizing quality of life before and after bypass surgery. However, participants' race and ethnicity were not disclosed in this study. The next section explores the uniqueness of African American volunteers.

African American Volunteer History

African American volunteer history expands over two centuries in the Black community through churches, business, and civic action. Marx (2000) found that African American philanthropy was a product of the church and the nonprofit services derived from the church. Marx (2000) also found that the church was even more influential in African American philanthropic history because it faced fewer restrictions than other institutions. As an example, poor Black colonists were often denied assistance in the colonial poorhouse system of public assistance. In the early 1800s, state laws in Virginia, Maryland, and North Carolina banned the formation of charitable societies by African Americans (Billingsley & Caldwell, 1991). Often, African American establishments unrelated to the church had to conceal their purpose and activities. Thus, Marx (2000) often found that in-kind services were frequently offered in place of money. For this reason, volunteerism plays a central role in African American philanthropic history.

Marx (2000) found that African American women used philanthropy as a tool to promote equality in addition to fulfilling other basic needs. Perhaps the most well-known example is Harriet Tubman's volunteer work with the Underground Railroad. However, less famous African American women were also engaged in philanthropic activities, including mutual aid organizations and women's clubs. For example, 24 African American women created The Phyllis Wheatley Home Association in 1897 to provide housing for elderly African American women in Detroit, Michigan. A second example was the National Association of Colored Women, an organization that offered employment services, childcare, and kindergarten to homeless African Americans (Marx 2000). Carter and Marx (2016) explored African American volunteering in the year following the 2008–2009 recession to determine factors influencing volunteering. African Americans were found to be highly motivated to assist fellow community members in times of crisis to ensure the overall health of the community.

Summary

The literature review found substantial studies on volunteerism and philanthropy in the African American community (Carter & Marx, 2016; Marx, 2000). However, little to no research offered insight from the perspective of the African American male (Billingsley & Caldwell, 1991). In the seminal Tuskegee syphilis study, African American men were unwilling participants to harmful medical research. The results of the Tuskegee era research were distrust and fear of the medical community from African Americans that have continued to this day (Gamble, 1997; Kennedy et al., 2007). SCT and HBM were utilized as theoretical guideposts for this study. Historically, peer

volunteer health workers positively influenced health promotion among minorities (Arvey & Fernandez, 2012; Burr et al., 2018; Krantz et al., 2013).

Furthermore, the literature acknowledged that there was no nationally standardized definition of a community health worker (Heisler, 2009; Krantz et al., 2013; Sokal & Fisher, 2016). Moreover, volunteers differ based upon the organization or disease they are supporting (AHA 2018; Boothroyd & Fisher 2010; Fisher et al., 2015; Kennedy et al., 2007; Willock et al., 2015). Yet there are similarities that exist among community health workers that include having a unique understanding of the target population, being well respected in their community, as well as having a genuine desire to help (AHA, 2018; Eng & Young, 1992; Heisler, 2009; Parry & Watt-Watson, 2009; Roseland et al., 2013; Sokal & Fisher, 2016). It was learned that prior to 1970, studies conducted on heart disease used predominantly Caucasian subjects. However, as time progressed the use of African Americans as participants in heart disease studies increased (Eng & Young, 1992; Dubbin et al., 2017; Lukachko et al., 2014). The interplay of structural racism and heart disease among African Americans was confirmed in several studies (Dubbin et al., 2017; Kennedy et al., 2007; Lukachko et al., 2014; Parashar et al., 2012; Shim, 2005; Warren-Findlow & Prohaska 2008).

In conclusion, the literature suggests that African Americans have played a significant, though largely underreported role in social political volunteerism. Furthermore, studies on the community contribution of African American males in medical volunteerism goes unreported. In the next chapter, a thorough review of the methodology will be discussed.

CHAPTER III

METHODOLOGY

The purpose of this phenomenological study was to explore the lived experiences of African American peer support volunteers who worked in healthcare settings. African Americans suffer from heart disease at a disproportionate rate in comparison to other racial/ethnic groups (AHA, 2018; CDC, 2017). Despite progress made in the medical field, this population continues to be at a significant disadvantage when it comes to the aftercare following cardiac surgery (AHA, 2018; CDC, 2017). A critical component of the aftercare for patients involves helping the patients understand their near-death experiences and the life changes they will need to incorporate to face life after the cardiovascular incident. Researchers have found that the best volunteers to do this type of counseling are people who have suffered a cardiovascular incident or who have been the caregivers of others who have experienced heart trauma (Heisler, 2009). Included in this section are discussions about qualitative research, participants, recruitment of participants, informed consent, field test, protection of human subjects, data collection, data analysis, and a summary.

Qualitative Research

A phenomenological approach guided the qualitative study. Phenomenology is a process that emphasizes the experiences of the phenomena in order to determine its essence (Bernard & Ryan, 2010). Marshall and Rossman (2016) found that

phenomenology readily identified the lived experiences of the participants. Moreover, phenomenology allowed the researcher to harvest the robust bounty inherent in life experiences (Seidman, 2006). The purpose of selecting this methodology was to understand the participants' unique experiences in their social contexts. Qualitative research gives researchers better tools to capture the nuance of lived experiences. Another important part of qualitative research is the participant/observer role of the researcher (Orbe, 2000). However, researchers must be aware of the risks and biases, as well as balancing the insider versus the outsider roles (Creswell, 2013).

Participants

This study focused on a specific phenomenon, and it allowed for establishing an understanding of how the concept might exist across settings or within various contexts (Schram, 2006). For the purpose of this study, I examined how the phenomenon impacted African American male peer support volunteers who visited cardiovascular disease patients in a healthcare setting. Sampling was a crucial component of the research process for this study and research validity. Purposive sampling method was used to select participants who had experienced the phenomenon (Bogdan & Biklen, 2007). The targeted number of participants for this study was 10 African American men serving as peer support volunteers for cardiovascular patients. Participants were selected based on the inclusion criteria and the ability to accomplish the research objectives. The inclusion criteria for participants included: (a) self-identified as African American, (b) male, (c) hospital volunteer, (d) actively volunteered within the past five years, and (e) English speaking.

Recruitment of Participants

Step One

After approval of the Texas Woman's University (TWU) Graduate School, I contacted leaders of organizations to recruit potential participants. The researcher gave each of the sources a recruitment flyer outlining the scope of the study and description of the participants needed for the study.

Step Two

These sources, who were gatekeepers familiar with their constituency, provided the researcher with contact information of potential participants who met the inclusion criteria of the study. This form of recruiting is known as purposive sampling, in which the researcher's known associates help identify other potential candidates (Marshall & Rossman, 2016; Shenton, 2004). Another way to describe this process is known as the snowball technique, which is useful when it is difficult to identify participants for the study, such as African American male participants (Shenton, 2004). Snowball sampling is an analogy of the participant pool increasing in size as interactions and awareness of potential candidate's increases, like a snowball rolling downhill (Shenton, 2004).

Step Three

The researcher contacted potential participants via email or telephone, to ensure they met the inclusion criteria to participate in the study. The researcher used a telephone script when communicating with potential participants (see Appendix A). Participants who met the inclusion criteria were scheduled for a date and time for the interview, face-to-face, or telephone. Telephone interviews were used at the participant's request or in

cases where the participants lived more than 100 miles away. If the participant did not meet the eligibility criteria, they were thanked for their time. For this study, 14 persons were screened and 10 were accepted as participants in the research study.

Step Four

Prior to each interview, the researcher contacted the potential participant and confirmed the date, location, and time of their interview as well as sent them a copy of the informed consent. The telephone interview participants were required to return the document prior to the interview. On the actual day of the interview, the researcher greeted each potential participant.

Protection of Human Subjects

A researcher has the responsibility to anticipate ethical issues that can arise during the research process consisting of human subjects, and that existing ethical and legal standards are maintained (Bogdan & Biklen, 2007; Denzin & Lincoln, 2008).

Researchers have the responsibility to respect the rights of the participant delineated in the informed consent. The informed consent allows participants the opportunity to make autonomous and informed decisions regarding study participation (Denzin & Lincoln, 2008). Informed consent also helps to develop trust among the researcher, participants, and promotes research integrity. Finally, the informed consent is for the protection of the researcher, and the institution against behaviors that can negatively impact them (Klitzman, 2011). The TWU Institutional Review Board approved the study prior to data collection.

Informed Consent

Once selected for participation, each participant received the informed consent prior to participating in the study (see Appendix B). Each participant was able to read the informed consent document while the researcher read it out loud. The participants were given an opportunity to ask questions, and the participants were also advised of their right to withdraw without penalty at any time during the interview process. When all questions were answered, the participant was asked to sign the documents. The researcher provided a copy of the document to the participant for their records. Lastly, the researcher reiterated to the participant their right to withdraw from the study at any time without any consequences.

Field Test

The researcher conducted a field test with four peer support volunteer experts, who were not part of the study. The experts consisted of a nationally renowned cardiovascular pharmaceutical manager, a nationwide manager of cardiac peer support training, a local manager of hospital volunteers, and a president of a cardiac peer support volunteer chapter. According to Shenton (2004), establishing early familiarity with the culture of participating organizations prior to collecting data adds credibility to the research. The purpose of the field test group was to ascertain the effectiveness and appropriateness of the questions to elicit accurate information from the participants regarding the phenomena (Creswell, 2013). The experts provided feedback on the quality of the questions, both demographic and interview, proposed for the study (see Appendix C). These experts reviewed and rated the relevance of the questions and their

effectiveness for AAMCPSV participants and their recommendations are listed in Figure 3.1.

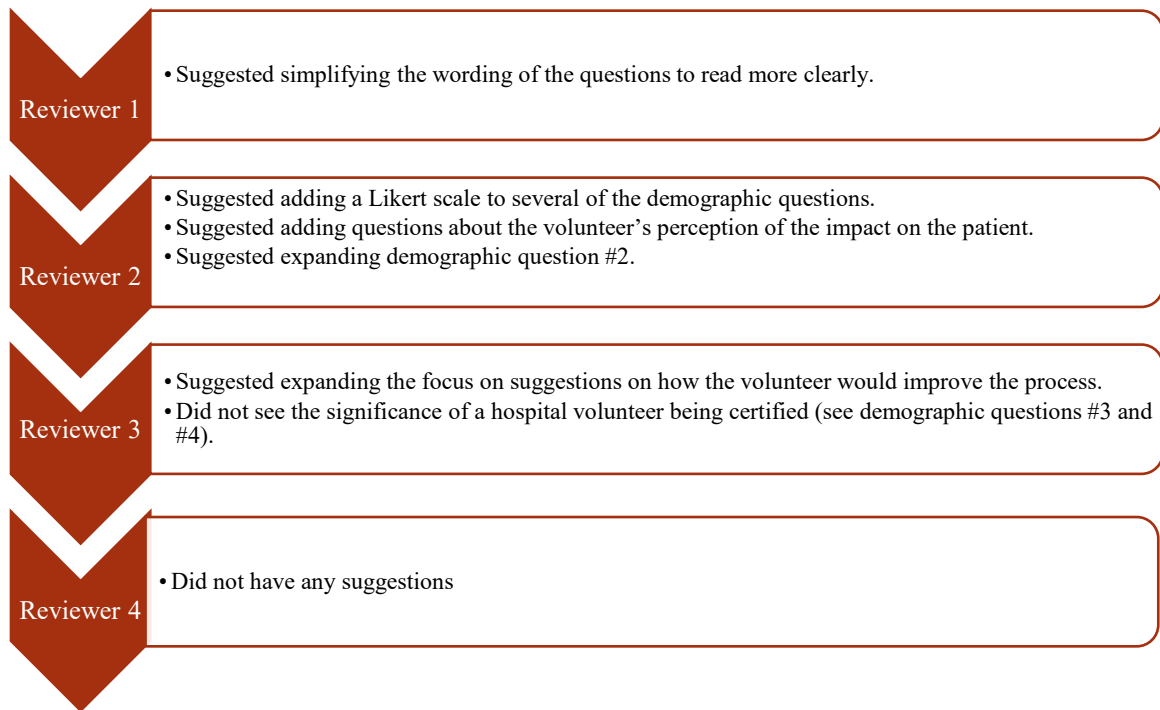


Figure 3.1. Interview question feedback.

Interview Questions

The feedback from the field test and the research team was used to develop a set of open-ended questions. The open-ended questions were grouped into four categories: (a) patient experience, (b) benefits of volunteering, (c) supporting and coping strategies, and (d) peer support training experience. The questions were circulated back to the peer support volunteer experts for a final round of input.

Table 3.1

Interview Questions

Theme	Questions
Patient experience	Describe the impact that you have had on the patients you work with? What are some of the challenges you have faced when working with patients?
Peer support training experience	What aspects of your volunteer training were particularly helpful? What aspects of your volunteer training were not helpful?
Benefits and challenges of volunteering	Describe, if any, the benefits that you have experienced in your role as a peer support volunteer? Discuss, if any, the benefits of being an African American cardiac peer support volunteer? Discuss, if any, the challenges have you experienced in your role as a PSV? Discuss, if any, the benefits of being a male CPSV?
Support and coping strategies	Describe, if any, the life events in your background that prepared you for the challenges you have experienced as a man with cardiovascular disease? Do you know of any programs or strategies to better inform other African American men about how to become a peer support volunteer? Are there any suggestions that you can give to help healthcare providers understand how African American men feel about being a peer support volunteers? What do you think will motivate other African American men to be peer support volunteers?

Data Collection

The phenomenology research design consisted of using one-on-one interviews as the primary data collection method. The use of semi-structured, one-on-one interviews allowed the researcher to ask questions related to a specific topic and for the participants to verbalize their experiences. A transcript of every participant's responses to the questions were created from the data (Creswell, 2013). The researcher used an open-ended interview guide to assist in interviewing the participants (see Appendix C).

Semi-structured interviews were used to gather responses of the participants. The semi-structured interview format provided greater breadth of richness in the data and allowed the participants autonomy to answer questions and describe their experiences without the limits of closed-ended questions (Babbie, 2013). The use of semi-structured interviews in a research design can be used to promptly identify concerns related to the subject matter and allow the subjects to respond immediately to the interview protocol. The use of semi-structured one-on-one interviews allowed the researcher the ability to observe the subject's emotional behavior in relation to the topic and examine the subject's feedback directly (Babbie, 2013).

At the beginning of each interview, the researcher took time to (a) reiterate the purpose of the interview meeting; (b) restate the study purpose, and; (c) review the agenda, structures, and guidelines of the session. The researcher wanted to create a safe and accepting environment for the participants to feel at ease and encouraged them to answer questions thoughtfully in their own words, which added depth and context to their responses (Seidman, 2006). The hope was that by creating such an environment, the

participants felt encouraged to disclose their perceptions, opinions, and emotions in a way that provided meaningful insight into the phenomena (Creswell, 2013). The researcher recorded all interviews on a digital recorder to capture all responses. A backup recorder was available in case of technical difficulty. After the interview, the participants were thanked for their time and given a \$10.00 Home Depot gift card.

Data Analysis

Phenomenological data analysis entails a three step process. The three steps are (a) description, (b) reduction, and (c) interpretation (Orbe, 2000). Each step is separate yet intertwines continuously into the other steps of the process. The purpose of the three-step process is to gain direct contact with the lived experiences of the participants in a healthcare setting (Creswell, 2013).

Description

The recorded interviews were transcribed verbatim into Microsoft Word documents. The returned transcripts were subsequently analyzed for themes and patterns. A major part of data analysis is analyzing transcribed data from participant interviews into similar categories and themes (Babbie, 2013). The researcher read the transcription fully and made highlights of those words that seemed to shed an understanding of the knowledge of the phenomena. The aforementioned process required several cycles until the participants' experiences become clear; and the truth was revealed regarding perspectives of the participants regarding the phenomena (Seidman, 2006). The coding process required usage of organizational tools including Microsoft Word and Excel. These tools assisted in accurately recording each step of the data analysis process.

Reduction

The reduction process is the second step of the three-step phenomenological data analysis process (van Manen, 1990). van Manen described the reduction process as the initial process of (a) refining, (b) expanding, (c) and discarding of the non-relevant data. According to Creswell (2013), this portion of the process begins the refining of information, in which the researcher separates non relevant data, in order to draw themes pertaining to the phenomena. The reduction process involved two major cycles that occur on top of each other (Patton, 2015). In each cycle, a series of interchanges happen among the researcher and the transcripts (van Manen, 1990). It was the rubbing together of data that yielded a meaningful and essential description of the lived experiences of the participants (Creswell, 2013; Patton, 2015).

Interpretation

The last stage of the three-step process is the interpretation process, also called the hyper-reflection cycle (Orbe, 2000; Saldaña, 2013). During this stage, the researcher set aside time for reflection and bracketing of experiences and my preconceived biases and how they contributed to the understanding of the phenomenon (Saldaña, 2013). Next, the researcher reviewed the themes and how they related to each other (Creswell, 2003). Ultimately, the researcher repeated the process of thematizing, bracketing, and interpreting until the meaning of being an AAMCPSV working in a healthcare setting emerged. As the researcher continued the reduction process, he uncovered phases and meanings that were not present during the earlier phases (Orbe, 2000; Saldaña, 2013).

Credibility and Trustworthiness

Central to any qualitative research is the issue of credibility (Shenton, 2004). Creswell (2013) found that a qualitative research effort that lacks credibility is barely worth the paper on which it is written. To establish credibility, the researcher solicited input from a diverse team of subject matter experts during the field test, this served as the first measure of credibility (Shenton, 2004). Next, the researcher used established methods of data collection such as, an interview questionnaire, a demographic survey, and data transcription (Shenton, 2004). Another level of credibility was frequent debriefing sessions with the research advisor who provided a sounding board to discuss research approaches, clarify perceptions, and maintain research focus (Shenton, 2004). The researcher received feedback on his dissertation results from peers who attended his research poster presentation at the 2019 National Council of Family Relations annual meeting.

Role of the Principal Investigator

As a researcher, my passion for this topic came from my experiences as an open-heart surgery survivor, caregiver, and volunteer. I have witnessed family members and friends dying from the effects of cardiac disease. I believe that their deaths in part resulted from their lack of understanding and reluctance to adopt needed lifestyle changes required to live with cardiovascular disease. These experiences permitted me to have a firsthand understanding of the tragedy of cardiac disease. Moreover, it deepened my understanding of the importance of having a support system in place that includes a

trusted and knowledgeable person who may help in understanding physician's orders and lifestyle changes.

According to Patton (2015), the experiences and background knowledge of the investigator with the phenomenon lend credibility to pursue qualitative research. Thus, my prior experiences and role as a cardiac volunteer in a healthcare setting are appropriate. Additionally, Saldaña (2013) postulates that there may be certain biases and judgments to qualitative research that cannot be eliminated. In order to minimize this bias, I used two additional coders to review the data. The additional coders held doctorate degrees in Family Sciences. While extensive effort was made to ensure objectivity, those biases may have shaped the way I viewed and understood the collected data and made interpretations of the participants' experiences with the phenomenon.

Summary

This phenomenological study was conducted to gain knowledge of the experiences, barriers, and perceptions of African American male peer support volunteers who worked with cardiovascular patients. The results of this study may help bring better understanding of the reasons these men are underrepresented in volunteer peer support programs in healthcare settings. The phenomenological approach chosen was perceived most effective in giving a voice to those rendered silent by traditional research methods (Leedy & Ormrod, 2010; Orbe, 2000). The research question guiding the study was: What are the lived experiences of AAMCPSV in a healthcare setting? Results from this methodology may provide health care leaders with strategies on how to recruit and retain more AAMCPSV.

CHAPTER IV

RESULTS AND FINDINGS

The purpose of this investigation was to explore the lived experiences of AAMCPSV's who provided care to persons living with heart disease and patients following a cardiovascular incident. Additionally, this study sought to understand the training experience of the participants. This chapter discusses the results and findings from the data collection process along with the findings (a) a description of the research setting, (b) participant demographics, (c) an overview of data analysis, (d) syntagmatic thematizations, and (e) emerging themes.

Description of Research Setting

The sample for this research consisted of 10 African American men with heart disease who volunteer to support other heart disease patients. Initially, 14 agreed to participate, but 10 signed and returned the informed consent form. Additionally, the participants served as support to others dealing with heart disease. Data were collected with the use of a demographic questionnaire (see Appendix C), an interview protocol for the individual interviews, observations, and field notes. Three interviews were conducted in person, and seven interviews were conducted on the telephone. In person interviews were conducted at a meeting location which was familiar to the participants. Telephone interviews were conducted at a convenient time for the participants. All interviews were recorded and then transcribed verbatim. Prior to starting the interviews, each participant was given a code name to be used during the study.

Demographics of the Sample

The demographic instrument (see Table 4.1) captured data that described the participants age, marital status, educational level, the age when they were diagnosed with heart disease, contact with peer support volunteers. All 10 research participants completed the demographic questionnaire and self-identified as African American males. Information collected on the participants included their: (a) chronological age, which ranged from 47 to 73 years; (b) the age range which heart the disease was diagnosed 53 to 69 years old; (c) the marital status, six married and four unmarried; (d) educational level, ranged from high school diploma to doctorate; (e) six participants received a visit from a cardiac peer support volunteer and four did not; and (f) six participants reported that the visit from a peer support volunteer was influential in their decision to become a volunteer.

Table 4.1

Research Sample Demographic Characteristics (N = 10)

Characteristics	Frequency	%
Age	n	
47	1	10
59	2	20
61	1	10
62	2	20
65	1	10
69	1	10
73	1	10
74	1	10
Age of onset of cardiovascular disease		
39	1	10
53	1	10
54	1	10
55	2	20
59	1	10
61	1	10
62	1	10
66	1	10
69	1	10
Marital status		
Married	6	60
Unmarried	4	40
Educational level completed		
High School	3	30
Associates	1	10
Bachelors	4	40
Masters	1	10
Doctoral	1	10
Received peer support visit		
Yes	6	60
No	4	40
Peer support visit influenced decision		
Yes	4	40
No	6	60

Syntagmatic Thematizations

What follows is a presentation of the initial themes revealed during the first cycle. Syntagmatic thematization is a process that begins by reviewing the essential themes and formulating ideas on how these themes relate to one another (Orbe, 2000). The following themes represent the assumptions, feelings, emotions, perceptions, experiences, and disappointments of the participants. This listing reflects all the themes that emerged as essential to the lived experiences of the African American male peer support volunteers. Established beneath every heading is a concise commentary on the relevancy of the theme coupled with the respondents' comments, and a participant number in parenthesis, which aids in clarifying who made the statement (Creswell, 2013; Patton, 2015). The goal of including this information was to help the reader comprehend the phenomenological process and the researchers' logic. This process provides an additional layer of complex analysis (Creswell, 2013; Patton, 2015).

The eight resulting preliminary themes are: (a) Providing Hope, (b) Benefits of Volunteering, (c) Enhanced Self-Esteem, (d) Families Were Helped, (e) Patients Could Be Candid about Their Sex Life, (f) Brother to Brother, (g) Peer Support Training, and (h) Shared Voices.

Providing Hope

The theme Providing Hope emerged from participant statements discussing the emotions, hopelessness, and frustrations patients endured as a result of being diagnosed with cardiac heart disease and the hope they perceived they brought to patients. Many participants expressed that when they met with their patients, they perceived that many

patients espoused that their life was over. The participants expressed that they brought insight and joy to the patients regarding their own experiences with being diagnosed with cardiac disease and how they survived it. They also shared ways that they helped patients by telling them stories, helping them make strategies, talking about lifestyle changes the patients need to make and issues they may have with families. Participant 7 commented, “Initially they were depressed and fearful of their medical situation. I can recall them feeling better after about it after my visit.” Other statements from the peer support volunteer participants are listed below:

Helping them understand what to expect. (Participant 8)

My story of getting a heart transplant is motivating the patient. (Participant 6)

It's important for me to remind them that their loved ones can come back from the surgery. (Participant 6)

I had a story of hope and recovery that I could share with others. (Participant 4)

Often when people are facing heart surgery or heart failure immediately the family and surrounding community start planning for death. In that situation, it's important for me to remind them that their loved one can come back from the surgery. (Participant 6)

Benefits of Volunteering

The second theme, Benefits of Volunteering, evolved as the participants discussed benefits they received from serving as peer support volunteers. The participants expressed joy, happiness, and pride to have such an impact on another individual and their family. Another benefit espoused by the participants was that serving as a volunteer

also made them mindful of their own health. Several participants discussed the benefits as spiritually transformative, such as expressed by Participant 4: “I wanted to be able to encourage other people in the same way that a volunteer motivated me right after the surgery. I promised God that if I got through the surgery, I would help others. I had a story of hope and recovery that I could share with others.” Following are the entirety of statements that went with this theme:

I was able to make a positive difference in someone’s life. (Participant 4)

If the patient was a man, I could help him overcome his fears. Sometimes I could bring out the questions that he was afraid to ask or did not know how to ask.

(Participant 3)

It’s important for me to remind them that their loved one can come back from the surgery. (Participant 6)

I’m helping to save a family. Because there are many families that we get to see and they have questions as well, and some of the family members, especially spouses are particularly grateful for our support. (Participant 8)

It made me feel better [and] improved my self-esteem. (Participant 3)

I feel very good when I help pull someone through the process. (Participant 10)

As a volunteer I get much more in return than I give. The rewards to me are tremendous. (Participant 1)

Enhanced Self-Esteem

The theme of Enhanced Self-Esteem developed out of the participant recollections of the positive feelings they experienced from serving in the volunteer role

of cardiac peer support volunteers. Many of the participants expressed that they felt an endorphin like, spiritual joy from being able to help someone avoid dying, such as expressed by this participant, “Seeing the look, in the patients’ eyes when they realize that they can survive and thrive...I feel like I am fulfilling my commitment to God.” (Participant 6). The sentiment of joy and jubilation of helping others was universally expressed by all of the participants. Other participants expressed that they perceived pleasure from being a peer support volunteer, as expressed by Participant 8: “I have received the most pleasurable life being a volunteer because I get to feel like I might have touched or saved somebody's life.” The rest of the comments for this theme are listed below:

I enjoy giving hope to the family. It makes me feel good to be able to help others. I can never give back as much as I have been given. (Participant 6)

I feel very good when I help pull a person through the process. (Participant 10)

I was able to make a positive difference in someone’s life. My efforts helped to save a family. It made me feel better [it] improved my self-esteem. (Participant 3)

I benefited by being able to bring some sunshine into the patients’ life. Whenever I could, I would reach out to the family to encourage them. It was a boost to my self-esteem. (Participant 7)

It is a boost to my self-esteem when a patient does well. As I see them improve over a couple of months. (Participant 5)

I got a chance to help somebody else going through what I'd already been through. To help relieve some of their fears I guess you get more out of it.

Then you get a boost to your self-esteem. (Participant 10)

There's a lot to be said for helping someone, and know you made a difference no matter how small. (Participant 3)

He [the patient] had a positive output. It's something I look at to say, OK this yeah I can just do this. I'll be OK. I'll be OK. So that your own self-esteem made you feel good. Oh, I feel because I had to I have to share. OK, what I went through. (Participant 3)

Families Were Helped

The theme Families Were Helped emerged from the participants' statements recalling conversations with caregivers and family members of the patients who expressed all types of emotions because their loved one was going through a cardiac crisis. Many of the participants expressed that they became the person for families who often didn't understand the cycle of the cardiac disease or what should be done to help the patient, as expressed by Participant 3: "You have seen family members in a hospital where they have previously lost a brother or other family member. So, you have to help them overcome the fear that it may happen again with the patient [you are working with]." The participants identified the emotions they are most often called upon to assist family members with is fear, which had many dimensions, such as the fear of not knowing the health outcome of the patient. The other statements that help to define this theme are listed below:

One of the things that Mended Hearts volunteers are particularly well known for are is known for is not only dealing with the heart patient but the caregiver. (Participant 3)

I visited a man who was not from this country, he and his daughters were so grateful for the help that we've given them in explaining how things were run and everything else. So, we made a big difference. (Participant 1)

There are some patients that we visit that family members aren't present but there are others that family members are, and they have questions as well, and some of the family members, especially spouses. (Participant 8)

It was also helpful to know what their spouse or support a person may have experienced or some of that feedback was that helpful to what the caregiver experience. (Participant 3)

So, I always emphasize with the family that I have to be strong for the family and let them know that-- because a lot of times the caregivers don't have the support that the patient does. The patient gets the doctors and nurses and everybody. The caregiver doesn't get any of that. So, I like to let them know, "Hey look, there are times when you just need to talk away from this so you can think. You also need to take care of yourself because sitting up in a hospital's not healthy." I've even gone as far as taking caregivers away from the hospital just to take them out to eat to get away from that thing because it's very traumatic. And that support from the family means a lot to that patient. But they can't help if they're not helping themselves. (Participant 4)

One of the things that Mended Hearts is particularly well known for is not only dealing with the heart patient but also the caregiver. (Participant 3)

The crisis also affects the patient's family and their loved ones because they're worried more about them than the person themselves. (Participant 6)

Patients Can Be Candid about Their Sex Life

The theme Patients Can Be Candid about Their Sex Life evolved from the participant statements discussing the male patient's concern over their limited sexual performance that often occurs with the onslaught of cardiovascular disease. The male patients were able to discuss with the participants more freely than with their doctors, their emotions, fears, and concerns related to erectile dysfunction. Another aspect the male African American volunteers identified as being important to their role was their ability to reduce the patient's anxiety because the volunteer had been in the same condition as the patient and could fully function as a Black male as expressed by Participant 6; "When I am speaking with African American men, I tell them that they can have a normal sex life after the surgery, in many cases their sex life will be much better. There is a great deal of relief on the patients face when we have that discussion. They know that they have hope of functioning as a 'complete' man again."

The topic of sexual function is a major concern of African American male patients but often were not communicated to the healthcare team. The African American male volunteers discussed how they become trusted agents of the African American male cardiac patients. They related conversations about sexual intimacies and concerns which the patient would not share with anyone else on the healthcare team. These

private conversations were crucial to the patient's compliance attitudes and their motivations toward healing, as stated by Participant 8, "Some men want to know if they will be able to perform sexually after the surgery. I tell them that it is very possible. In my case the sex was better. I encourage them to work with their doctor."

The entirety of participant comments on this theme are listed below:

I told the patients that many other patients were able to return to normal functioning. (Participant 5)

Some men have the misguided idea that they will be able to perform like they were 20 years old. I candidly remind them that they can get better. (Participant 4)

There was a 70-year-old patient who wanted to know if it was safe to have sex after surgery. (Participant 7)

Brother to Brother

This theme, Brother to Brother, evolved from participant conversations about the positive reception they received from the male African American cardiac patients when they entered their rooms. The volunteer became more of a symbol of hope to the patient who often was going through all sorts of uncertainties with life expectancy, not sure of what was to come, forced into sharing intimate information with healthcare personnel whom were often White and did not quite understand the Black male perspective. as revealed by Participant 4, "So when another African American sees another one, it kind of gives them hope to the point where now they're not isolated. If that makes any sense."

The African American male volunteer could not only relate to the patient, they helped the patient abide by the recommended health advice. They spoke to the patient in

such a way that it took away the patients excuses, because they had experienced the same life and health issues as patient and now could lead them to be survivors, as expressed by Participant 8, “Being African American, I can readily discuss some of the stressors that confront African American [males] with a higher level of credibility.”

Another issue that the male, African American volunteers identified was the lack of trust the African American, male patients had toward their doctors. The lack of trust impacted the patients’ health outcomes and caused them to not fully follow the advice of doctors because they perceived the White doctors would not work as hard to save them, as expressed by Participant 6,

Yes, a lot of the patients I visit are male, African-American men. And a lot of them have a mindset that the doctors are not going to work as hard to save them. Knowing our [African American] history with the [unethical medical] experiments like the Tuskegee experiment. So, there's a lot of distrust with doctors, ...a lot. So that's another issue that has to be overcome in our community.

The entirety of participant statements on this theme follows:

Some patients can relate to me better particularly if they are Black (Participant 3).

When some of those patients [African American] see you in that capacity as a black man, they [display] a sense of pride in seeing you. (Participant 7)

When I speak to other African American men, they get very hopeful when they see that I had a successful outcome. (Participant 9)

So I think what you're saying is that being black in some cases gives a greater trust they can see into you could depend on the person you're talking to but more importantly is what the initial bond is your brotherhood or sisterhood the relationship of the heart. (Participant 4)

My patient stated, "Well I don't trust a White doctor." (Participant 4)

Peer Support Volunteer Training

The Peer Support Volunteer Training theme evolved from participant conversations about the training the volunteer participants underwent. The participants reflected on the training as adequate, as described by Participant 6, "Well, I think all training is necessary. I don't think any training should be taken away.... I would like to see more." Other peer support volunteers expressed that their training was centered in the patient's room and helped them be mindful of the heart patient's health status and concerns, such as stated by Participant 3

It gave me a little more insight to the common concerns that heart patients have I had known of the clinical aspects of heart patients but this gave me a more intimate knowledge of some of the things that heart patients shared among themselves that I was able to convey to heart patients that it was beneficial.

It is important to point out that training was not standardized for the peer support volunteers and depended on the hospital setting they volunteered at, as expressed by Participant 4, "In training, it's important to stay on point and sometimes those in charge of training would go off on different tangents and not stay on the subject" (Participant 4).

I can't say that there was any. Everything that I received in my training has been very helpful not only in my visiting patients, but it's helped me in an everyday situation. (Participant 8)

The most helpful part of the training was how we trained to go into the patient's room and talk to them. Do not take any personal things or issues into the room. (Participant 9)

Be very aware that this person is going through a traumatic experience. Always be extra careful when you go in these rooms because they're sick and there's a lot of diseases. So you have to go in protecting yourself as well. There was always someone available to help if you ran into a problem. Just pick up the phone and call. (Participant 6)

Shared Voices

This theme, Shared Voices, evolved over the many recommendations the volunteers had for healthcare leaders and administrators. The perceptions illustrate the ways in which peer support volunteer programs can be enhanced, especially for the African American male volunteers. It was suggested more than once that the African American male peer support volunteers perceived that they should be more involved with the healthcare team since their perspective will allow the healthcare team to better understand the underlying emotions and feelings of the African American cardiac patient, as stated by Participant 4:

...being black in some cases gives [you] a greater trust. So that the patient can see into you. And, depending on the person you're talking to but more importantly on the initial bond of your brotherhood or sisterhood is the relationship of the heart.

Other recommendations described prejudicial and stereotypical ways in which these African American, male volunteers perceived they were treated in the hospital settings. The volunteers were distinguished in their earlier lives and wanted to make a difference in their communities, which is why they became healthcare volunteers. However, more than one of the peer support volunteers received little to no value as part of the medical team despite their value to the patient, as espoused by Participant 6:

Yes, a lot of the patients I visit are male, African-American men. And a lot of them have a mindset that the doctors are not going to work as hard to save them. Knowing our [African American] history with the [unethical medical] experiments like the Tuskegee experiment. So there's a lot of distrust with doctors, ...a lot. So that's another issue that has to be overcome in our community.

African American male cardiac patients also expressed their reactions to the importance of the volunteer, as related by Participant 6: "They, [African American health volunteers] need to let [healthcare leaders] know how valuable they are in saving people's lives."

Not being recognized by insurance companies and not fully recruited were also concerns and recommendations from the volunteer health workers. The entirety of the recommendations are listed below:

I would say they probably need to reach out more. A lot of hospitals and places don't reach out to African American men because there's still this stereotype. It's not true. Well I think people fear blacks, and I don't know why. (Participant 6)

Be more attentive to some of the concerns or issues that we might have as people

as far as stress factors, as far as helping with as I stated earlier some of our environmental issues aiming in different things that we do that's not conducive to us [Blacks]. Sometimes, I feel that some providers of more hospitals-- they hear you, but they don't hear you. It's like if you're not in my shoes, then you don't know how-- what it's like to be an African American male in today's society. (Participant 8)

Insurance companies do not really understand just how much of a difference we make in terms of saving them money by making sure they get better patient outcomes. Do you think they appreciate that role we play! (Participant 6)

I would tell the patient that they're going to have a cardiac adviser. Come in and speak to him and how to make their life easier after the procedure. They will generally cooperate because everybody wants to feel better when he's in the hospital. Once the patient becomes aware [of the visit] the way is paved for someone [the volunteer] to come in and talk. (Participant 5)

I guess they would have to get something going to alert blacks that they need to volunteer more. Perhaps they can go to the churches. (Participant 7)

Essential Themes

The next step of the phenomenological process requires organizing the themes into a complete description of the phenomenon experienced by the participants (Creswell, 2013). This process renders the preliminary themes into a smaller number of broader themes as major findings of the research study. The thematization of ideas represents the continual aspect of reflection that peeled away at the statements to uncover the true

meaning of being an AAMCPSV serving in a healthcare setting. This process included comparing and contrasting all preliminary themes until they were condensed into a table of four essential themes (see Figure 4.1).

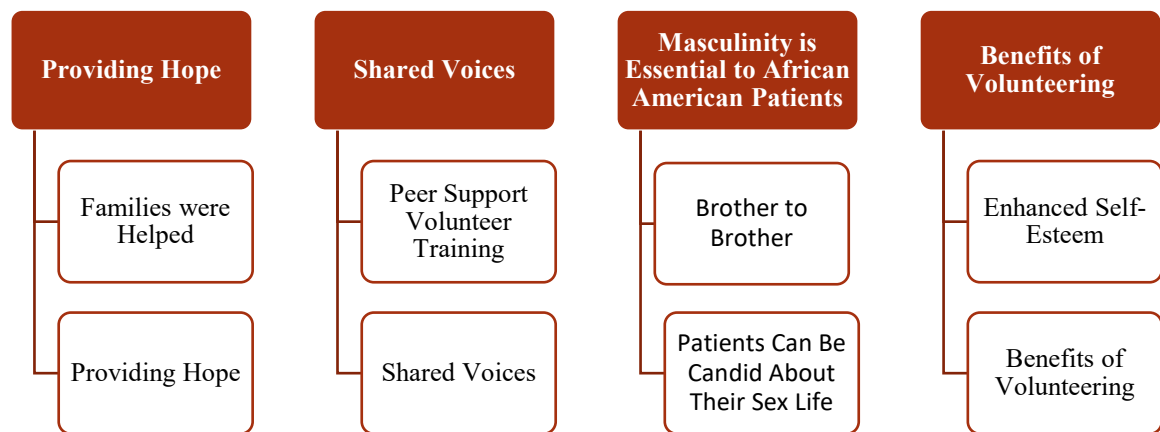


Figure 4.1. Essential themes

Providing Hope

This essential theme evolved as a combination of Providing Hope, and Families Were Helped. These two themes were appropriate to convey the experiences of the participants, with patients and family members after the patient was diagnosed with cardiac heart disease. This theme conveyed how having the support of a trusted person, one who has experienced the same health crisis can create hope, as illustrated by these participants:

“Often when people are facing heart surgery or heart failure immediately the family and surrounding community start planning for death. In that situation, it's

important for me to remind them that their loved one can come back from the surgery.” (Participant 6)

You have seen family members in a hospital where they have previously lost a brother or other family member. So you have to help them overcome the fear that it may happen again with the patient [you are working with]. (Participant 3)

“You just got a second chance at life. You know your whole life just turned around. You got more years left now! If you hadn't had this surgery where would you be? Your wife and your loved ones would be planning a funeral.”

(Participant 10)

Benefits of Volunteering

This essential theme evolved from the continual reflection and refinement of themes: Benefits of Volunteering, and Enhanced Self-Esteem. The themes had in common the joy, exuberance, and spiritual emotions of the participants regarding their role as cardiac peer support volunteers. The sentiment of joy and jubilation of helping others was universally expressed by all of the participants, which they described as a benefit to them and to the patient they were helping: “Seeing the look, in the patients’ eyes when they realize that they can survive and thrive...I feel like I am fulfilling my commitment to God” (Participant 6).

Every participant discussed their own health status and how they survived their cardiovascular incident. They also discussed how close they were to dying. The participants found that serving as a volunteer also made them mindful of their own health status, as stated by Participant 1, “As a volunteer, I get much more in return than I give.

The rewards to me are tremendous.” Participant 6 stated: “I know for a fact that we can get complacent with our medicine and then start taking things for granted. Actually, in May 2008, my heart stopped, they [the emergency room team] had to do CPR on me for 59 minutes to bring me back.”

Masculinity Is Essential to African American Patients

This theme resonated as an essential to defining the themes that included the statements describing how the participants bonded with each other-- Brother to Brother and Patients Could Be Candid about Their Sex Life. Central to these themes is the participant and patient expressions of what it is like to be a man living with heart disease. “Being African American, I can readily discuss some of the stressors that confront African American [males] with a higher level of credibility” (Participant 9).

What evolved from this theme is the importance of sexual functioning to African American male patients. African American males living with heart disease are statistically more likely to suffer from erectile dysfunction and are often too ashamed to discuss this issue with their spouse or in any other forum. The sensitive topic of sexual performance in many ways gets to the essence of manhood and governs the patient’s emotional desire to engage in the recovery process. “Some men want to know if they will be able to perform sexually after the surgery. I tell them that it is very possible. In my case, the sex was better. I encourage them to work with their doctor” (Participant 6).

Participants discussed the ethnic pride that many patients felt when they saw the volunteer was African American, as stated by Participant 7: “When some of those

patients [African American] see you in that capacity as a black man, they [display] a sense of pride in seeing you.”

Shared Voices

This essential theme is a combination of the preliminary themes: Shared Voices and Peer Support Training. The theme evolved because of the statements of advice for the healthcare community. This reflects the high level of professionalism and esprit de corps on the part of the volunteers. These participants know their efforts save lives.

Be more attentive to some of the concerns or issues that we might have as people as far as stress factors, as far as helping with as I stated earlier some of our environmental issues [eating] different things that we do that's not conducive to us [Blacks]. Sometimes, I feel that some providers of more hospitals-- they hear you, but they don't hear you. It's like if you're not in my shoes, then you don't know how-- what it's like to be an African American male in today's society.

(Participant 8)

Most of the participants were generally happy with the level of training they received, they simply wanted more of it, as stated by Participant 6: “Well, I think all the training is necessary. I don't think any training should be taken away.... I would like to see more.”

Summary

This chapter gives an overview and analysis of the 10 interviews and themes generated. The first reduction analysis of the participants' lived experiences. Further analysis of the data reduced the information into four essential themes: (a) Providing

Hope, (b) Benefits of Volunteering, (c) Masculinity is essential to African American Patients, and (d) Shared Voices. Chapter Five consists of a final synergistic reduction of the data, compared and contrasted with the research literature from Chapter Two. Chapter Five culminates with the researcher encapsulating the lived experiences of the participants serving as AAMCPSV.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this phenomenological study was to explore the lived experiences of AAMCPSVs who worked in a healthcare setting. Previous research on this topic was scarce, especially when it came to include the voices of African American men who were volunteers (Barg et al., 2012; Parry & Watt-Watson, 2009). The volunteer challenges discussed in Chapter Two covered areas such as the historical and cultural perspective on peer support volunteers, social support aspects of peer volunteers, and the unique characteristics of the African American volunteers. Berkman et al. (1992) found that many of the evaluations emerging in the early 1990s were topical narratives. From these evaluations, most researchers concluded that volunteer health workers have contributed positively in promoting health and increasing utilization of social and economic services (Burr et al., 2018; Krantz et al., 2013). However, little to no studies specifically explored African American men in the cardiac healthcare volunteer community.

The researcher will focus here on the final meanings associated with what it is like to be an African American male volunteering at a hospital setting working with African American cardiac patients. This chapter also focuses on conclusions about the research organized by the research question and interview questions that led to essential and preliminary themes in Chapter Four. These conclusions are based on a final synergistic reduction that includes the researcher's interpretation of the data. The conclusions are compared to previous research on the topics. Another section focuses on

the relationship of the findings to the existing volunteer and health literature of Chapter Two. Chapter Five concludes with the limitations and recommendations for future study. The research question that guided this study was:

What are the lived experiences of African American male peer support volunteers who work in a healthcare setting?

In the following sections the researcher compares study findings with the existing literature in order to establish the complete meaning of being an AAMCPSV in a healthcare setting. The essential themes compared include (a) Providing Hope, (b) Shared Voices, (c) Benefits of Volunteering, and (d) Masculinity is Essential to African American Patients.

Providing Hope

The findings of this study highlight the contributions of the African American men to the cardiac healthcare team and African American community. In addition, the findings of this study illustrate the ways in which the AAMCPSV impacts the African American male cardiac patient, his family, and the healthcare community as a whole, as expressed by Participant 6, “The crisis also affects the patient’s family and their loved ones because they're worried more about them than the person themselves.”

Overwhelmingly, the theme Providing Hope helps to illustrate how having the support of a trusted person, of the same ethnicity and gender, inspires the patient and loved ones, as expressed by Participant 6: “Often when people are facing heart surgery or heart failure immediately the family and surrounding community start planning for

death. In that situation, it's important for me to remind them that their loved one can come back from the surgery.”

Previous research indicated that African American men make up a very small percentage of volunteers in minority communities (Billingsley & Caldwell, 1991; Carter & Marx, 2016; Marx, 2000). This study’s findings illustrate that although the numbers of African American men in healthcare may be small, their contribution within the cardiac healthcare community is significant. These volunteers helped members in the African American community return to a healthy life, impacting the negative aspect of increasing rates of African American cardiac disease in this country.

Shared Voices

The findings of the theme, Shared Voices, consisted of concerns and fears of the African American male cardiac patient and the AAMCPSV. Existing literature found that peer support workers were increasingly employed to serve as sources of advice, information and support, and a bridge between the community and the healthcare service delivery system (AHA, 2018; Heisler, 2009). This study’s findings address a gap in the literature related to the role of the AAMCPSV provides to the male cardiac patient and their families, which also positively impacts their community. In addition, the findings of this study illustrate that the aspect of the bridge that represented the healthcare system was riddled with challenges for the AAMCPSV, as illustrated by these participants:

Be more attentive to some of the concerns or issues that we might have as people as far as stress factors, as far as helping with as I stated earlier some of our environmental issues aiming in different things that we do that's not conducive to

us [Blacks]. Sometimes, I feel that some providers of more hospitals-- they hear you, but they don't hear you. It's like if you're not in my shoes, then you don't know how-- what it's like to be an African American male in today's society.

(Participant 8)

Insurance companies do not really understand just how much of a difference we make in terms of saving them money by making sure they get better patient outcomes. Do you think they appreciate that role we play! (Participant 6)

Benefits of Volunteering

Within the theme Benefits of Volunteering, this study found that by serving as a volunteer the AAMCPSV improved his own health. The social interchange between the AAMPSV and the African American male cardiac patient also boosted the self-esteem of the AAMPSV, as expressed by Participant 6: “Seeing the look, in the patients’ eyes when they realize that they can survive and thrive...I feel like I am fulfilling my commitment to God.” Previous literature has shown that increased levels of social support in protecting against cardiac relapse within the general population (Parry & Watson, 2009; Rankin & Quane, 2002).

The study also found that it is important to have the support of a trusted person of the same race and ethnicity; as it was crucial to disease self-management and wellness to identify barriers that interfere with Black men’s self-management of heart disease. Those barriers were identified as the family, masculinity, loss of hope, and the ability to have a better quality of life (Long et al., 2017). This study supports Long et al. (2017) by extending the results of their research to include African American male cardiac health

patients. The findings of this study further update Long et al. (2017) by showing that during the recovery of African American male cardiac patients, AAMCPSVs are important to include in the healthcare team.

Masculinity Is Essential to African American Patients

The findings of this study also brought to light gaps in the literature related to African Americans, heart health, and living in a racist environment (Dubbin et al., 2017; Lukachko et al., 2014). These studies found that for the African American patient, the behaviors that lead to the development of cardiovascular disease were closely tied to their level of social support. The findings from this study enhanced the literature by identifying core health, social, and life stressors of African Americans that are impacted by racism, as related by:

“Being African American, I can readily discuss some of the stressors that confront African American [males] with a higher level of credibility.” (Participant 8)

“Yes, a lot of the patients I visit are male, African-American men. And a lot of them have a mindset that the doctors are not going to work as hard to save them. Knowing our past history with experiments like the Tuskegee experiment. There's a lot of distrust with doctors, ...a lot! That's another issue that has to be overcome in our community.” (Participant 6)

Another finding of this study seldom found in the existing literature that fear was identified as a hidden and underlying issue impacting wellness of the African American male cardiac patient. Fear was presented in several dimensions such as hostility, misplaced emotions, and sexual dysfunction. It was conversations with the peer support

volunteer who had experienced the same types of fears during their management of heart disease that this came to light. One of the most frequently talked about subjects between the peer support volunteer and cardiac patient was about sex. Although the healthcare team was well-intended, it was difficult for the patient to discuss sex-related concerns because of the limited time healthcare providers have to spend with a patient. As reflected by Participant 3, “If the patient was a man, I could help him overcome his fears. Sometimes I could bring out the questions that he was afraid to ask or did not know how to ask.”

Themes Related to Theory

This section compared the essential themes (a) Providing Hope, (b) Shared Voices, (c) Benefits of Volunteering, and (d) Masculinity is Essential to African American Patients, with the tenets of SCT and the HBM. Shenton (2004) found that relating a qualitative researcher’s findings to previous research lends credibility to the findings.

Central to SCT is the construct that learning takes place through modeling, observation, and behaviorism (Bandura, 1986). Within the theme Providing Hope, SCT is illustrated in the interactions between the AAMCPSV and the African American male patient. This creates a model in which the heart patient may learn heart healthy life skills from a trusted person of the same gender and ethnicity. This model also extends to the heart patient’s family.

SCT was illustrated in the theme Benefits of Volunteering. Within this theme, the range of interactions between the African American male patients and the AAMCPSV

becomes a modeling experience for the AAMCPSV. When the AAMCPSV observes the struggles of the patient, he is reminded of his own painful history and struggles with heart disease. The AAMCPSV perceived that if he does not maintain a healthy heart protocol, he will become the patient, hospitalized and possibly facing death.

SCT is also found within the theme of Masculinity is Essential to African American Patients. Within this theme the SCT is illustrated within the conversations (observation and behaviorism) between the African American patient and the AAMCPSV. The patient related their fears about changes in their masculinity, such as sexual performance. Fears of losing their spouse or family as well as their ability to be the leader of their household were also major concerns of the patient.

Central to the HBM is the constructs of personal susceptibility, seriousness of threat, perceived threat, benefits of outcomes, cues to action, and cost benefit analysis (see Figure 2.2). Within the theme Providing Hope, the AAMCPSV is an agent of change who helps the patient understand the severity of the diagnosis and changes required to overcome. The AAMCPSV also helps the patient understand the cues to action (diet, lifestyle, and stress reduction) and the cost benefit analysis to help the patient understand the lifelong changes that are needed.

Within the theme Shared Voices, the African American male patient and the AAMCPSV expressed their concerns related to their disease healthcare team and limitations of hospital policies related to AAMCPSV. These concerns were expressed as a cost-benefit analysis of participating in research. The patients related fears of the past unethical treatment of African Americans in medical care and research (Kennedy et al.,

2007). The AAMCPSV expressed their experiences of being inconsequential to the medical team as well as an overall lack of respect.

Within Masculinity is Essential to African American Patients, personal susceptibility, seriousness of threat, and perceived threat. These constructs focused on reduced quality of life, family history, death, severity of diagnosis, and underlying life concerns. The AAMCPSV was able to tap into the underlying fears of the African American male patients by helping them bring those fears and emotions to the surface.

Recommendations to the Healthcare Community

The AAMCPSV was also successful in bridging the knowledge gap between the African American cardiac patient and the healthcare community. In their mission to save lives, the AAMCPSV deemed it necessary to inform the healthcare community on the issues that impact the African American community. Although there were limited studies that focused on this topic, understanding health issues of the cardiovascular patients as a whole is important, and vitally important is the limited studies especially the Black male patient (Kennedy et al., 2007; Shim, 2005; Sokol & Fisher 2016). So, hearing the often-silent voices of AAMCPSV in the literature will go a long way to bringing understanding of their healthcare issues and ways to improve healthcare delivery to this ethnic population.

Implications for Family Life Scientists

The findings of this study focused on the African American male, cardiac patient and his family that are facing a life and health crisis. The AAMCPSV is assigned to this family. The volunteer becomes a mentor and guide for the patient and family throughout

the health crisis. The American Heart Association (2018) predicted an alarming increase in heart disease particularly for African American males for the next decade.

The results of the study present several implications for both the policy and practice of Family Life Educators. Implications are offered for family life educators specifically and to the healthcare community in general (National Council of Family Relations [NCFR], 2020). These study findings address four components of family life doctrine: (a) families and individuals in societal contexts, (b) internal dynamics of families, (c) human sexuality, and (d) family life education methodology (NCFR, 2020).

Families and Individuals in Societal Context

The implications are that there are not enough African American male peer support volunteers for the number of African American men living with and dying from cardiac disease. Additionally, it is vital that the peer support volunteer be of the same gender and ethnicity as the patient to be able to navigate them through the lifestyle changes needed.

Internal Dynamics of Families

The implications are that the diagnosis of heart disease introduces chronic stress to the African American male cardiac patient and his family. The study findings illustrate the internal dynamic forces that are in play within the family during a cardiac health crisis and their need for a trusted person to help them cope.

Human Sexuality

The implications are that the sexual health of African American men is a significant part of overall wellness that are often hidden and unaddressed. The research

identified the critical role that the male African American peer support volunteer played in helping the patient understand the sexual changes occurring within his body that impact his masculinity.

Family Life Education Methodology

This research included the voices of African American male peer support volunteers that were limited or nonexistent in previous research. The peer support volunteers uncovered barriers to improving the patient's heart health that traditional approaches may have missed. The implications are that family life educators can improve methods and practice in family sciences.

General Recommendations

Healthcare Leaders

Two recommendations given (a) increase funding on African American male cardiac health outreach, and (b) increase the recognition and value of the AAMCPSV within the healthcare team.

Community and Civic Leaders

(a) make alliances with local universities and or healthcare organizations to develop connections and research projects on the cardiac health priorities of African American community residents; (b) create a cardiac health advisory committee—to ensure all research aligns with the African American community values; (c) create a civic advisory committee consisting of bi-partisan leaders (business, church, school); and (d) create outreach programs in which AAMCPSV influence and mentor the youth in healthy heart habits.

Academic Leaders

Increase the research funding on peer support volunteerism on African American males.

Limitations

While completing this research project, limitations and questions surfaced concerning the phenomenon of African American male peer support volunteers serving in a healthcare setting. Certain limitations exist when using phenomenology as a methodology (Leedy & Ormrod, 2010). First, research limitations can occur when using a person as an instrument. Second, research bias can also occur when using purposive sampling (Leedy & Ormrod, 2010). Third, sampling of only 10 AAMCPSV decreases the generalizability of study findings of this population on a regional and/or national basis (Creswell, 2013; Leedy & Ormrod, 2010). Finally, it may be difficult for a person to understand the phenomenon without experiencing it and having the same knowledge as the participants' understanding of the phenomenon. Readers who do not share the same perspective or experiences with the phenomena may struggle with the findings of this dissertation. However, in this case, this general limitation was minimized since the research was conducted by an AAMCPSV serving in a healthcare setting.

Recommendation for Future Study

A recommendation for future studies is to use the same methodology, phenomenology, and do a regional study on African American males in a hospital setting to compare findings for consistency. Additionally, using a mixed-method study utilizing male and female African American cardiac peer support volunteers to compare for gender

uniqueness. Another recommendation is to do a national study comparing race, gender, and cardiac health outcomes in a hospital setting. Finally, develop cross-cultural dialogs and focus groups among healthcare administrators, peer support volunteers, and cardiac health teams. These cross-cultural dialogs may help to build to stronger organizations. These conversations may lead to cultural diversity workshops, cross-cultural training about bias, stereotypes, and other multi-cultural topics to assist all stakeholders to feel more comfortable within healthcare settings.

Reflections and Lessons Learned

This study was enlightening for revealing the importance of having a trusted ally of the same ethnicity and gender. This finding was also important for illustrating the motivational health benefits emerging from the bond between patient and volunteer. The study revealed how the perception of racism can affect the perception and ability of the peer support volunteer to be a valued member of the healthcare team. For healthcare administrators, the research shed light on how an unwelcoming environment can degrade the health outcomes of African American cardiac patients. These proud men were distinguished in their community and driven by their passions to improve the health of their friends and neighbors. Further, the men wanted to improve the quality of care offered by the institution. In addition, this valuable information can be used by family life educators to understand the perspectives of the African American male patient, his family, and the AAMCPSV.

Summary

This chapter consisted of a final synergistic reduction of the data, compared research findings with the literature. The research question guiding this study was: What are the lived experiences of African American male cardiac peer support volunteers working in a healthcare setting? The four essential themes developed were: (a) Providing Hope, (b) Benefits of Volunteering, (c) Masculinity is Essential to African American Patients, and (d) Shared Voices.

The key findings of this research study from the perspectives of the AAMCPSV are the African American peer support volunteer is the most capable member of the healthcare team to help guide the cardiac patient and family out of the crisis, volunteering to the African American patient improves the cardiac health of the volunteer and the patient, masculinity and sexuality are underlying and under-recognized concerns, and the AAMCPSV want to empower other African American males to join the cause.

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APPENDIX A
TELEPHONE SCRIPT

Telephone Script

When caller identifies himself as a potential participant interested in the study, PI will proceed as follows:

“Thank you for calling. My name is Charles Michael Coleman, and I am a doctoral candidate at Texas Woman’s University in the Department of Family Sciences”.

The purpose of the qualitative study is to explore the perceptions and experiences of African American male peer support volunteers.

“Before enrolling participants in the study, I need to determine if you are actually eligible to participate. I would like to ask you a series of questions. All of the information I receive from you by telephone, including your name and any other identifying information will be kept confidential”.

1. Do you identify as African American male?
2. Are you an American citizen?
3. Do you speak English fluently?
4. Have you been certified as a hospital volunteer at facility that performs open heart surgery?
5. Have you actively volunteered in the past five years?
6. Would you be willing to complete a demographic questionnaire voluntarily? [not wanting to complete the questionnaire will not disqualify the caller from participating in the study].

If the participant is not eligible, I will say the following: “Sir, thank you for your interest in the study. Based on your answers, it appears you are not eligible to participate in this research study. Before we end our call, do you know of anyone that you believe would be interested in the study?”

If the participant is eligible, I will say the following: “Based on your answers, it appears you are eligible to participate in the research study?”

Now, I will read the consent form to you.

After reading the consent form, I will then ask the individual if they would like to be a participant in the study. If they say no, I will thank the individual for their time; ask them if they know anyone that they believe would be interested in the research study; then I would say goodbye.

If the participant replies yes, “What questions do you have at this time for me? (All questions will be answered by the PI).

What interview time slot will work best for your schedule?

I will call you with a confirmation two days prior to the date you selected to participate in the in-depth interview. The confirmation will include the date, time, and location of the in-depth interview.

Thank you for your time. I look forward to meeting you on the date, time, and place we agreed upon.”

APPENDIX B
INFORMED CONSENT

Informed Consent Participants 18 Years of Age and Older

TEXAS WOMAN'S UNIVERSITY (TWU)
CONSENT TO PARTICIPATE IN RESEARCH

Title: A phenomenological study with African American male cardiac peer support volunteers.

Principal Investigator: Mike Coleman.....ccoleman8@twu.edu 940/898-5555
Faculty Advisor: Joyce Armstrong, PhDjarmstrong@twu.edu 940/898-1111

Summary and Key Information about the Study

You are being asked to participate in a research study conducted by Mr. Mike Coleman, a student at Texas Woman's University, as a part of his dissertation. The purpose of this research is to explore the lived experiences of African American male peer support volunteers who work in healthcare settings. As a participant you will be asked to take part in a face-to-face interview regarding your experiences as a peer support volunteer. This interview will be audio recorded, and we will use a code name to protect your confidentiality. The total time commitment for this study will be about 2 hours. Following the completion of the study you will receive a \$10 gift card for your participation. The greatest risks of this study include potential loss of confidentiality and emotional discomfort. We will discuss these risks and the rest of the study procedures in greater detail below.

Your participation in this study is completely voluntary. If you are interested in learning more about this study, please review this consent form carefully and take your time deciding whether or not you want to participate. Please feel free to ask the researcher any questions you have about the study at any time.

Description of Procedures

As a participant in this study you will be asked to spend 90 minutes of your time in a face-to-face interview with the researcher. An additional time of approximately 30 minutes may be needed to verify information after the interview. The researcher will ask you questions about your experience as a cardiac peer support volunteer. You and the researcher will decide together on a private location where and when the interview will happen. The researcher will decide on a code name for you to use during the interview. The interview will be audio recorded and then written down so that the researcher can be accurate when studying what you have said. In order to be a participant in this study, you must be at least 18 years old.

Potential Risks

The researcher will ask you questions about how your experience as a peer support volunteer. A possible risk in this study is discomfort with these questions you are asked. If you become tired or upset, you may take breaks as needed. You may also stop answering questions at any time and end the interview. If you feel you need to talk to a professional about your discomfort, the researcher has provided you with a list of resources. Another risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. The interview will be held at a private location that you and the researcher have agreed upon. A code name, not your real name, will be used during the interview. No one but the researcher will know your real name.

Approved by the
Texas Woman's University
Institutional Review Board
Approved: June 20, 2019

Initials
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The audio recording and the written interview will be stored in a locked cabinet in the researcher's office. Only the researcher, his advisor, and the person who writes down the interview will hear the audio recording or read the written interview. The audio recording and the written interview will be destroyed within three years after the study is finished. The signed consent form will be stored separately from all collected information and will be destroyed three years after the study is closed. The results of the study may be reported in scientific magazines or journals but your name or any other identifying information will not be included. There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings and internet transactions.

The researchers will remove all of your personal or identifiable information (e.g. your name, date of birth, contact information) from the audio recordings and/or any study information. After all identifiable information is removed, your audio recordings and/or any personal information collected for this study may be used for future research or be given to another researcher for future research without additional informed consent.

If you would like to participate in the current study but not allow your de-identified data to be used for future research, please initial here _____.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will try to help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. Following the completion of the study you will receive a \$10 gift card for your participation. If you would like to know the results of this study, we will email or mail them to you.

Questions Regarding the Study

You will be given a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask the researchers; their contact information is at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the TWU Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

Signature of Participant

Date

*If you would like to know the results of this study tell us where you want them to be sent:

Email: _____ or Address: _____

Approved by the Texas Woman's University Institutional Review Board Approved: June 20, 2019
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APPENDIX C
DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Demographic

1. Do you have heart disease_____?
2. If yes how old were you when this happened_____?
3. When you were hospitalized for your heart incident did you receive a visit from cardiac support volunteer?
 - a. Yes_____
 - b. No_____
4. If yes, did the visit influence your decision to become a volunteer?
 - a. Yes_____
 - b. No_____
5. What is your marital status?
 - a. Married_____
 - b. Unmarried_____
 - c. Cohabiting_____
6. What is your highest level of completed education?
 - a. Did not attend / graduate from high school_____
 - b. High school_____
 - c. Associate_____
 - d. Bachelor_____
 - e. Masters or higher_____
7. On average how many patients do you visit during a month_____?

APPENDIX D
INTERVIEW QUESTIONS

Interview Questions

Patient Experience
1. Describe the impact that you have had on the patients you work with?
2. What are some of the challenges you have faced when working with patients?
Peer Support Training Experience
1. What aspects of your volunteer training were particularly helpful?
2. What aspects of your volunteer training were not helpful?
Benefits and Challenges of Volunteering
1. Describe, if any, the benefits that you have experienced in your role as a peer support volunteer?
2. Discuss, if any, the benefits of being an African American cardiac peer support volunteer?
3. Discuss, if any, the benefits of being a male, cardiac peer support volunteer?
4. Discuss, if any, the challenges have you experienced in your role as a peer support volunteer?
Support and Coping Strategies
1. Describe, if any, the life events in your background that prepared you for the challenges you have experienced as a man with cardiovascular disease?
2. Do you know of any programs or strategies to better inform other African American men about how to become a peer support volunteer?
3. Are there any suggestions that you can give to help healthcare providers understand how African American men feel about being a peer support volunteers?
4. What do you think will motivate other African American men to be peer support volunteers?
5. Thinking about what you went through with training to be a peer support volunteer to date, is there anything which you feel is important that I have not asked?

APPENDIX E
INVITATION LETTER

Dear Participants,

My name is Charles Michael Coleman and I am a doctoral student at the Texas Woman's University pursuing my Doctorate in Family Studies. I am conducting a study on African American cardiac peer support volunteers. My goal is to gain a better understanding of your experiences with cardiovascular patients.

Your participation in this study will include (a) completing a demographic questionnaire, (b) participation in a one-on-one interview, and (c) providing informed consent. Your participation in this study is voluntary, which will last 1.5 to 2 hours and will be audio taped, with your permission. All information will be kept in a safe and secure location for 3 years. After 3 years, all confidential material, paper records, and audio tapes will be destroyed. If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself. The interview will be conducted at a time and safe location that is convenient for you. The question will relate to your lived experiences with cardiovascular disease. During our initial meeting, I will ask you to complete the questionnaire before beginning the interview. The final set of questions, in the form of a written questionnaire, will relate to your health background and demographic information.

To participate in the study, you will be required to sign the informed consent form to acknowledge that you understand your role and rights in the study. All information will be kept confidential and used only for the dissertation. I hope you will respond to this letter and be a part of the interview process.

Sincerely,

Charles Michael Coleman

Doctoral Candidate Texas Woman's University

ccoleman8@twu.edu

(940) XXX-XXXX