The Relationship of Trust in the Health Care System and Perceived Hope to the Quality of Life Satisfaction Among Adults in Alabama's Expanded Black Belt

by

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Abstract

This quantitative study explored the quality of life in a historically depressed area in Alabama's Black Belt where trust in the health care system has been challenged secondary to a landmark sentinel event altering the use of the healthcare marketplace, the agency and agenetic paradigms of the residents. The United States Public Health Service (USPHS) Study of Untreated Syphilis on the Negro Male commands new and historical rhetoric, the significance and impact of racism in medicine, mistrust of the health care system and the impact of these phenomena on the agency of minority members of society. The Black male in the 21st century continues a historical and long standing struggle in the health care marketplace, having the shortest lifespan of any gender among all races in the United States (U.S) of major race groups, which influences the accrual of gaining an adequate education impacting negative conjectures of socioeconomics, the accrual of social and human capital, which can and often evokes his critical presence in the criminal justice system.

Trust is paramount for positive agency in all realms of social relationships, inclusive of health care. The operationalization of positive or negative hope can impact the quality of life for residents in a depressed system in the Deep South, with a historical legacy of racism and medical mistreatment. Data analyses implicate mistrust as significant in the faith based community from which the sample were derived. Findings from the study have the potential to help formulate future intervention models to promote a more positive trusting relationship with the health care system.

The essence of the dialogue which continues in the 21st century, significantly questions the healthcare agency of people of minority status and the perpetual, cyclic and multigenerational processes influencing the continuation of inequities associated with health and the resulting health care and health disparities.

Dedication

He is the strength of my life — he is the source of my strength!
I lift my hands in total praise to Him!

Amen-Amen (Smallwood)

This work is dedicated to the precious memory of my father, Revered John William Floyd, Educator/Administrator/Pastor of Bethel Baptist Church. A pioneer educator, becoming the first Black principal of Evergreen High School in a time when race relations in the deep south contended with intimidation and more overt conflictual structural arrangements. Not only did he endure the challenges and changes in the racial landscape, but also succeeded in constructing a 1.8 million dollar sanctuary—Bethel Baptist Church in Monroeville, Alabama—after accepting a call to ministry.

Having a great love for God, humanity, and possessing an emphatic concern for the enhanced quality of life for all students, but specifically directing, embracing and helping to give voice to Black students, emphatically in their quest toward educational attainment, self-actualization and positive educational outcomes; becoming a role model to many, having obtained three degrees during a different era in time from Alabama State University, Atlanta University and Selma University (with the exception of failing eyesight from pursuing a doctorate). On one occasion I remember him telling his granddaughter who was vacillating over college career plans, stating to her, “You need to get a college degree; it can be in dog catching, but just get a college degree”.

John William Floyd leaves the legacy of being “tough but fair” as a disciplinarian particularly from an administrative stance—but most of all he was just “My Daddy”. I remember as a child of approximately 8–9 years of age going with my father and mother to Atlanta University, where “My Daddy” was going to meet with his advisor for guidance with his Master’s Thesis in Administration. There was something uniquely special about that experience; vivid and graphic illustrations remain imprinted in my conscious mind even today. After meeting his advisor, Dr. Boyd, we all went to eat lunch (I now know the significance of that event). A memory of paperwork being strewn all over our house and envelopes with his Instrument for data collection provided a reality to this process. The bound maroon volume of his work once completed with the onion skin paper (that felt so gentle to my hands), I would often pull down from the shelf, review and treasure. I called it “his book”, of which I now honor more with a distinct relevance. He paved the way—allowing me to gain insurmountable and immeasurable social and human capitol. I understand now, as I read about disparity theory, that we are but a composite of our experiences.

The legacy of John William Floyd dictates, for those of us who have been blessed in ways that others haven’t, a responsibility to help “others” along the way. And, that’s what I was taught more than anything else from the philosophy of which John William Floyd lived, and the legacy which he left (by no means perfect) but “…he went about doing good.” Through this process of writing, I now understand why the length of time for completion has been great—I had to embrace the legacy of which John William Floyd lived and not to turn others away, who needed my help in the maize of life and living—in essence our lives are not own, we sustain a mission of self-sacrifice in our Christian walk and journey, no matter the personal cost.

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Jesus, you are the center of my joy
All that's good and perfect comes from you.
You're the heart of my contentment – hope for all I do
Jesus, you are the center of my joy.

Smallwood

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"When I've lost my direction, you're the compass for my way. In sadness, you're the laughter that shatters all my fears, when I'm all alone, your hand is there to hold. You're the source and finish, of my highest dreams." (Smallwood)

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List of Abbreviations

AL	Alabama
CVD	Cerebrovascular Disease
CDC	Centers of Disease Control
CRT	Critical Race Theory
DDHS	Department of Health and Human Services
HEW	Health Education and Welfare
HIV	Human Immunodeficiency Virus
IOM	Institute of Medicine
KKK	Ku Klux Klan
MMWR	Morbidity and Mortality Weekly Report
NESRI	National Economic & Social Rights Initiative
NHDR	National Health Care Disparities Report
NIH	National Institutes of Health
PHCR	Public Health Critical Race
PNI	Psychoneuroimmunology
PHS	Public Health Service
SDH	Social Determinants of Health
SEDSC	Southeast District State Convention
TB	Tuberculosis

U.S.	United States
USDHHS	United States Department of Health and Human Service
USPHS	United States Public Health Service
TSUS	Tuskegee Study Untreated Syphilis
VA	Veterans Administration
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Hope…a high sense of expectation, regardless of history and current circumstances.
Healing is a way of releasing power to others rather than holding on to it oneself.
(Warren, 2011; Campbell, 1985)

While the United States (U.S.) health care system has an expansive capacity to treat serious medical illness, it is and remains a troubled system! "People of color have long fought for equal access to health care as part of the struggle for civil rights" (National Economic & Social Rights Initiative [NESRI], 2010, p. 4). According to Gamble (1997), the lack of trust in the health care system has tholed for centuries, inhibiting equitable access to the health care system, and marketplace, particularly for minorities and the poor. The United States Public Health Service (USPHS) Study of Untreated Syphilis in the Negro Male occurring from 1932–1972 without informed consent is representative of a primary model of unethical, intentional and wrongful experimentation, evoking distrust and fear in Black Americans of the health care system and commands historical and current dialogue relative to class, gender and race in an unethical abuse of power of the federal government to mostly poor sharecroppers and tenant farmers in Tuskegee, Alabama and surrounding towns in Macon County. Williams and Williams (2011) conveyed,

> The nation's longest longitudinal observational research study, a study of untreated syphilis in African American men residing in medically, socially and economically underserved Macon County, Alabama, is the most egregious exemplar of research misconduct in our nation's history. The study demonstrated the persistence and

> pervasiveness of racism, deception, and exploitation in medicine and research. African American men of Macon County were encouraged to enroll for treatment of "bad blood." Rather than being treated, they were observed through the course of disease progression to death and autopsy. (p. 69)

The influence of mistrust in the healthcare market place is significant. Byrd et al. (2011) posited, "Distrust of the medical community, inadequate education, low socioeconomic status, social deprivation, and underutilized primary health care services all contribute to disproportionate health and health care outcomes among [Black Americans] compared to their Caucasian counterparts" (p. 480). LaVeist, Bowie and Cooley-Quille (2000) conveyed, "Black persons are more likely to report mistrust of the health care system, which leads to less willingness to use health services" (p.10). It has been implicated that poor health care stifles growth and productivity, with a lack of hope hindering a positive agency, evoking despondency and apathy leading to a poor quality of life satisfaction (Hendricks, 1998a).

Health equity is still not realized by all American citizens. Sadana and Harper (2011) posited, "Health inequities flow from…patterns of social stratification—that is, from the systematically unequal distribution of power, prestige, and resources among groups in society" (p. 6). Bayer, Gostin, Jennings and Steinbock (2007) further postulated, "Inequality in patterns of morbidity and mortality are clearly tied, … to inequalities in other dimensions of human social life (p. 167). There are many theoretical conceptualizations which provide credence and dialogue to the continued disparity in health care. The social gradient theory is significant in disparity research (Bayer, et al., 2007). Bayer, et al. postulated, "Inequalities of wealth, power, and social status correspond to inequalities of health, illness, and risk" (p. 167). Extending across time and societies, those who are at the pinnacle of the social hierarchy, "the rich and the powerful" will attain a higher health status than others (Bayer, et al., 2007, p. 167). The social gradient theory of inequality surpasses economic inequality, the significance of social relationships cannot be negated, "health disparities are also connected with inequalities of power and status" (Bayer, et al., 2007, p. 167).

In 1938, Gunnar Mydral, a Swedish economist was commissioned by the Carnegie Corporation to conduct, "a comprehensive study of the Negro in the United States, to be undertaken in a wholly objective and dispassionate way as a social phenomenon" (Mydral, 1944, p. ix). In 1944, *An American Dilemma: The Negro Problem and Modern Democracy* was published. An analysis was surmised by Mydral (1944) relative to healthcare. Myrdal (1944) found,

> Mortality in all age groups is much higher among Negroes than among whites. Negroes suffer more from nearly all sorts of illnesses. We have shown that at least the major part of these differentials is not due to greater susceptibility on the part of Negroes but *to* the impact of economic, educational, and cultural handicaps, directly or indirectly imposed upon Negroes by discrimination. The fact that Negroes are in greater need of health facilities than are whites, and that discrimination in providing them health facilities hurts the whites themselves, is gradually becoming realized. (p. 344)

Mydral (1944) actually introduced the social determinants of health, which influence how health care is constructed sixty nine years later in the United States. Actually, according to the Institute of Medicine (IOM; 2011), "The U.S. healthcare system is characterized by a high degree of fragmentation across many sectors which raises substantial barriers to providing accessible quality care at affordable prices" (p. 21). Interestingly,

> The health care system has varied meanings and is symbolic of status and influence, often serving as a caveat of power and elitism, with upper tier group members subordinating less power to those in the lowest tier, who often lack adequate power, altering the acquisition of social goods inclusive of health care. In the market-based system, 'Health care is a commodity bought and sold in the marketplace. Private, for profit entities are primarily accountable to shareholders.' (NESRI, 2010, p. 4)

Minority group members typically own less power in the racial structure in comparison to dominant group members and … "have more difficulty getting health care, have fewer choices in where to obtain care, and receive lower quality care than Whites" (NESRI, 2010, p. 4).

Brown and Flores (2011) posited,

> [A] healthcare system … can be thought of as imbued with a symbolic value which impacts on those who do not use it, as well as those who are its patients. Its very presence within a society, in all that it represents or fails to embody, has a much broader impact on the functioning of social systems and the attitudinal positions of actors within these. (p. 62)

Health inequities, inequality and disparities are pervasive and persistent for people of minority status. The Centers for Disease Control Mortality, Morbidity Weekly Report (CDC MMWR, 2011), defined a health disparity "…as differences in health outcomes between groups that reflect social inequalities" (p. 1). Provider bias, physician satisfaction, the lack of respect and trust for all health care consumers, are inclusive of the varied reasons for the lack of quality service and equity in the U.S. health care system. LaVeist, Isaac and Williams (2009) conveyed the significance of mistrust in the role of health care agency and the influence of the social determinants on equitable health outcomes.

Byrd and Clayton (2000) dissertated on the relevancy and impact of a lack of social goods and the influence on health outcomes. A dearth of social goods intersects with social determinants of health for people from socially disadvantaged backgrounds altering agency and positive health outcomes. According to Braveman et al. (2011),

> Social disadvantage refers to the unfavorable social, economic, or political conditions that some groups of people systematically experience based on their relative position in social hierarchies. It means restricted ability to participate fully in society and enjoy the benefits of progress. Social disadvantage is reflected, for example, by low levels of wealth, income, education, or occupational rank, or by less representation at high levels of political office. Criteria for social disadvantage can be absolute (e.g., the federal poverty threshold in the United States is based on an estimate of the income needed to obtain a defined set of basic necessities for a family of a given size) or relative (e.g., poverty levels in a number of European countries are defined in relation to the median income, e.g., less than 50% of the median income). (p. S151)

In 2002, the Institute of Medicine (IOM) relayed findings in a report entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* commissioned by the U.S. Congress. After an extensive review of the health care literature garnering over 600 citations, according to Smedley, Stith and Nelson (2002) this report found, “Racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life” (p.17).

Smedley, Stith and Nelson (2002) posited, “Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in health care" (p. 178). Byrd et al. (2011), in a recent study on exploring and clarifying motivations and barriers specific to African American men across age ranges, relative to their participation in research studies verified the violence and devastation which exists for the Black male in the 21st century healthcare system and the critical need to include large numbers of African American males in research studies, more significant so, given their "disproportionate burden associated with many chronic diseases" (p. 480, p. 482).

Harrison and Dean (2011) provided credence to the significance of gender equity in the health care market place and confirmed, "Gender equity [as] an often-overlooked determinant of health" (p. 1). Issues of gender inequity in social relationships and stratification are significant. Black males are unduly burdened in various sectors of American society and suffer inequitable outcomes. On average, the life expectancy for Northern European American males is 74 years, while the Black male is 66 years and has been lower than Northern European American males for well over 40 years (Bayer, et al., 2007). Bayer et al. (2007) further acknowledged in an analysis by Deaton of a disparity in life expectancy by geography and race, which found in the U.S. a 20-year gap existed in longevity between Black men who resided in the unhealthiest counties and Northern European American men who lived in the healthiest counties. Byrd et al. (2011) in a research study contended,

> Despite many improvements in the status of minority health, African American males continue to have the highest age-adjusted mortality rate of any race-sex group in the United States. Such disparities are accounted for by deaths from a number of diseases such as diabetes, human immunodeficiency virus (HIV), cancer, and cardiovascular disease, as well as by many historical and present social and cultural constructs that present as obstacles to better health outcomes. (p. 480)

When access to the healthcare system is inequitable, societal and personal goals are costly, which impacts the burden of disease and disability. The Agency of Health Care Research (2011) stated, “Racial and ethnic minorities and people of low socioeconomic (SES) status are disproportionately represented among those with access problems” (Para I). However, SES does not account fully for the lack of health equity for those who are disadvantaged in standards compared to majority members. Healthcare disparity research indicated, with the control of income, educational status and other variables, “The health status of racial and nonwhite ethnic minorities ranks lower than that of whites on numerous measures” (The Agency of Health Care Research, 2011, p. 391).

Access to the health care system particularly presents barriers for the uninsured. According to Arrow et al. (2009), 70 percent of Americans lack health insurance. Individuals that are uninsured often report use of fewer health care services with continued problems associated with costs and access (Institute of Medicine [IOM], 2008). However, it is evident that cost containment, quality care and access are impeded by fragmentation that results from the millions of underinsured and uninsured Americans. NESRI (2010) postulated,

> Evidence shows that the quality of care given to people of color is generally lower, including in the treatment of cancer, heart failure, and pneumonia. The 10 year survival rate for Black people with cancer is 48%, compared to 60% for Whites. People of color comprise more than half of those without health insurance, despite representing only one third of the total population. At the same time, most communities of color experience higher rates of disease and mortality than Whites. Racial inequities in health care are one of many factors contributing to significantly poorer health outcomes for people of color in the United States. (p. 1)

Findings indicated that approximately 22,000 people in the United States die every year because they lack health insurance and have dangerously limited access to care (Human Rights Info Sheet No. 1, January 2008, Para 3). McCarthy, How, Cantor and Belloff (2009) posited, "As reported in the inaugural *State Scorecard* in 2007, where you live within the United States makes a difference in your access to care, quality of care, and experiences with care providers" (p. 3).

Access, affordability and quality healthcare are barriers in the Black Belt counties of Alabama. "Alabama's minorities often have poorer access to care than Whites" (Alabama Heath Disparities Status Report, 2010, p. 2). Wimberley (2008), described the often unrecognized Southern Black Belt as being similar to Appalachia, and is home to residents where quality of life is unusually poor. Wimberley and Morris (1997) substantiated the Black Belt has a persistent history of: (a) poverty, (b) poor employment, (c) low income, (d) low education, (e) high infant mortality rates, and (f) poor health, (g) with a high rate of dependence. According to Wimberley (2008), a concentration of the South's' poor quality of socioeconomics is situated in the Black Belt. Wimberley (2010) conveyed the persistence of the poverty stricken legacy in the Black Belt. In actuality, the Black Belt counties are some of the poorest in the nation. Hattery and Smith (2007) have critically observed the reality of historical legacies which exist in the Black Belt South. These historical legacies, analyzed by Hattery and Smith (2007), encumber a unique persistence of implied structural inequities. Hattery and Smith (2007) postulated,

> The Deep South has often been characterized as the poorest and most backward region in the United States. The Deep South is also unique in that it is the most racially diverse part of the United States and it has the powerful social history of chattel slavery.… In

> the Deep South, quality of life and consequent life chances are shaped heavily by race and patterns of racial segregation. The Deep South is still highly racially segregated and this segregation impacts virtually every aspect of life. (pp. 55–57)

The findings from Hattery and Smith (2007) parallel findings from Mydral in 1944 and Vocino in 2011 regarding social shortcomings in race relations in the rural south. Recent studies continue to posit the entrenched inequitable power structure in the South relative to Northern European Americans and those so "othered" particularly, Black and Hispanic Americans which impact quality of life (Vocino, 2011).

The intersection of race, healthcare, socioeconomics and education impact life quality and are essential to the growth and productivity of a community. In *Assessing Quality of Life in Alabama-Counties in Crisis* (2011), a recently published manuscript by Alabama State University Center for Leadership and Public Policy reviewed domains in the aforementioned areas inclusive of: (a) health-care, (b) education, (c) economics and (d) public safety. The literature clearly implicates the criminal justice system as having an impact on the uncompromised agency of certain social groups accessing the health care system which intersect with major societal barriers, altering the acquisition of the necessary elements essential for a productive quality of life. Vocino (2011) posited, "No indicator speaks more to the public's perception of the concept of "quality of life" than that of healthcare, and it often serves as one of the most compelling bodies of evidence to truly describe a region" (p. 24). Quality of life is essential to the well being of community health impacting, the paradigmatic and physical agency of residents, in varied domains of life, profoundly affecting: (a) healthcare, (b) social and spiritual well being, (c) educational attainment, (d) safety, (e) socioeconomics, and (f) living and housing status (Endicott, 1993).

Quality of life in the Black Belt has many unique indices. The Black Belt has endured and sustains many structural issues which have remained constant for centuries. Wimberley (2008) described the Black Belt,

> as the ‘collective southeastern counties whose populations include higher proportions of Black Americans than the national average. But the region’s social significance is more than demographic: the Black Belt essentially equals the “Plantation South” and is distinguished by a legacy of extreme structural inequalities’. (p. 1)

In a recent appraisal of the Black Belt region, Wimberley (2010) surmised,

> Black contemporary research consistently locates the Black Belt within the 11 former Confederate states – Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia, which I also call “the South” – and assigns a county to the Black Belt if Black Americans’ percentage in its total population reaches a certain threshold. The threshold varies, ranging from 12 percent (Blacks’ percentage in the total U.S. population in the 1980 and 1990 Censuses), to 25, 33, and 40 percent. (p. 105)

Within these confederate states, six states are situated in the Deep South. Most writers acknowledge these states as: (a) Alabama, (b) Georgia, (c) Louisiana, (d) Mississippi, (e) North Carolina, and (d) South Carolina, while other scholars acknowledge the inclusion of the states of Virginia and Florida in the geographical region of the Deep South (White, 1994). Historically, the Deep South has a legacy of promoting the use of slaves as means of maintaining an economic and agricultural base, imbibing cotton as a main production of survival prior to the civil war, providing slave masters with an elegance and pseudoextragavant plantation life style (Freehling, 1972; Reif, Geonnotti, & Whetten, 2006). Aoki (2003) postulated,

> Economically speaking, racial slavery in the United States was a paradoxical institution. On the one hand, slavery clearly produced skewed distributions of wealth and resources, and some of the antebellum period's wealthiest individuals resided in the South. On the other hand, coercive efforts to harness unpaid labor productivity were not efficient means to generate wealth. Indeed, given the regional wealth discrepancy between the antebellum North and South, the "peculiar institution" of slavery may well have been economically *inefficient*. (pp. 742–743)

Without the use of slave labor in the Black Belt, the life style of the Northern European American citizenry in the rural south would not have existed in the situated extravagance of existence. Frantz Fanon, in the *Wretched of the Earth*, makes a comparison to the European pseudo opulence of existence and to the use of "others" in acquiring materialistic goods. Fanon (1963) conveyed, "The European opulence is literally a scandal for it was built on the backs of slaves, it fed on the blood of slaves…" (p. 53).

As a result of slave labor, "The emancipation of slaves in the South posed a serious problem for large landowners who had previously relied almost entirely on slave labor for their incomes" (Wright & Rogers, 2010, p. 8). Hattery and Smith (2007) further solidified the significance of the economical dependence of slave labor, and the hegemonic forces which existed in the southern states. Hattery and Smith (2007) posited,

> The Deep South, especially Alabama and Mississippi, developed an economy more dependent on slavery and, later, Jim Crow segregation than any other region, including other parts of the South (e.g., Virginia and North Carolina). Here, African Americans

> were and are relegated to a second-class status in comparison with their white counterparts. (p. 58)

While legal scholarship surmised the end of slavery in the United States, at the end of the Civil War, Wright and Rogers (2010) are in agreement, but further postulated, … "But of course its impact did not disappear simply because this form of racialized class relations had been destroyed. Slavery contributed to a particularly pernicious and durable form of racist beliefs that continues to influence American culture today" (p. 7).

Wimberley (2010) provides a further analysis of the Black Belt in situating the uniqueness of the region reflecting the substandard stubborn and entrenched living conditions for the majority of rural residents. Wimberley (2010) asserted,

> No place is more Southern than the Black Belt, yet the region's substandard socioeconomic conditions distinguish it from the rest of the South, a paradoxical contrast with the 'New South's' often-emphasized economic vitality of recent decades … the Black Belt's presence accounts for the South's poor rankings on many socioeconomic indicators compared with the rest of the U.S. (p. 10)

Alabama, situated in the Deep South has a history steeped in traditional inequities, impacting the "other" in hegemonic processes relegated to political, economic, education, healthcare, criminal justice, other social goods and inequitable structures, both institutional, systematic and systemic, limiting the actualized potential and agency of minorities and others not relegated to the upper hierarchical social tier. To further illuminate the significance of the entrenched legacy, the hegemony that the state of Alabama historically sustains and to situate historical specificity essential for the exploration of variables associated with this study, and the historical context of the USPHS Study of Untreated Syphilis in the Negro Male, it is essential to present an unbiased view of the state. Vocino (2011) provides an unscathed view of the historical dynamics embraced by the state of Alabama in a recent review of indicators associated with quality of life. In *Assessing Quality of Life in Alabama–Counties in Crisis*, Vocino (2011) posited,

> The state has long struggled with inequalities and injustice; Jim Crow laws, separate but equal, and *de jure* and *de facto* segregation have left an enduring smear on the state in the eyes of many. Though gone are the days of legal segregation, the long-term impact of repressive laws is still felt both in the state and throughout the Deep South. (p.36)

Vocino (2011) found a similar assessment of the south as Mydral (1944) regarding equality of the Negro race. Mydral (1944) acknowledged, “He is worst off in the rural South, where the most apparent racial discrimination is shown, at the same time as the general relief standards are very low. The South continues to be inconsistent in its treatment of Negroes” (p. 357). As Mydral (1944) posited, the persistence of being “worst off in the rural South” impacts many ramifications of difference in health and mortality.

According to Wimberley (2008), in reviewing 1980 census data which distinguished death certificate data geographically in comparison to Alabama’s Black Belt South residents to other residents of the Black Belt on a national level, findings indicated mortality rates occurred at higher levels in the Black Belt of Alabama than the non-Black Belt south. Conclusions could be drawn according to Wimberley (2008) that residents in the Black Belt South have a diminished quality to life satisfaction than residents residing in the non-Black Belt South. Wimberley (2008) posited the most important and salient aspect of quality of life is the avoidance of early death. Health care literature identified various reasons for differentials in mortality rates in Alabama’s Black Belt counties, inclusive of: (a) lack of access to providers,

(b) a dearth of financial resources, and (c) a legacy of inequitable structures of power. In essence, Black Americans in comparison to Northern European American counterparts impact the health care market place with allocated differences, often receiving less medical attention, encountering structural inequities, intersecting with a deficit of social goods. Rurality associated with the region impacts the quality of life of the residents. According to Wimberley, Morris and Woolley (2001) rurality is inclusive of various dimensions of social stratification which significantly alters social life, encompassing: (a) cultural distinctions, (b) patterns of social interaction, (c) quality of life, and (d) sparse or small populations and occupational characteristics. Key quality of life indicators in defining the region most often include an analysis of: (a) median income, (b) measures of poverty (i.e. child poverty and adult), (c) employment, (d) mortality (i.e. infant and adult), and (e) education (Wimberley, 2010).

Structural factors can pose significant health risks to the health of a community and the people who reside. According to Fenton and Dean (2010),

> …structural factors include those physical, social, cultural, organizational, community, economic, legal, or policy aspects of the environment that impede or facilitate efforts to avoid disease transmission. Social factors include the economic and social conditions that influence the health of people and communities as a whole, and include the conditions for early childhood development, education, employment, income and job security, food security, health services, and access to services, housing, social exclusion, and stigma. (p. 1)

Death certificates often listed the cause of demise in Black Belt residents as unknown, when this data was identifiable, which indicated minimal contact with physician—if any— prior to death. These findings in comparison to Northern European American counterparts are unequal and not as common (Wimberley, 2008). Explanations are varied regarding nuances associated with access—rurality—physical distance from providers does not fully account for the lack of physician contact. Medical mistrust is a factor that cannot be ruled out and perhaps is associated with underutilization of health care consumption, altering the agency of minority actors in the healthcare market place in the Deep South. Health care literature documents Black Americans are often more mistrustful of the health care system than their Northern European American counterparts and revealed numerous studies relative to the influence of mistrust of providers in services indicative to health care practices and or failure of Black Americans to participate in research trials and in the impact which the USPHS Tuskegee Study of Untreated Syphilis Study in the Negro Male. Although, some scholars report mistrust as not a viable factor for Black Americans in their command of the health care system with the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male as having no impact on the agency of Black Americans and the lack of perceived mistrust as having no influence on participation in research trials (Katz et al., 2006); however, a overwhelming body of knowledge supports mistrust as a factor and the impact of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male as being a problematic issue for Black Americans interfacing the health care system. Although Byrd et al. (2011) acknowledged,

> Recent investigators have begun to challenge the impact of the Tuskegee Study in accounting for the research participatory behaviors of African Americans. These investigators suggest—and we concur—that knowledge of the TSS is not necessarily inhibitory; there are general issues of trust among African Americans that stem from a history of unequal treatment in major social and political constructs. Other investigators have also shown that African Americans are just as willing as Whites to participate in

> studies. Yet, African American males remain underrepresented in research studies and clinical trials. (p. 481)

Interestingly, Katz et al. (2006) found, “Research in the process of health care has shown that ethnic minority patients receive less empathy, attention, and information from their doctors” (p. 5).

This study proposes to explore the quality of life in a historically depressed area in Alabama’s Black Belt where trust in the health care system has been challenged secondary to a landmark sentinel event. The sequelae of the event have possibly attributed to the health conditions, and may be a contributing factor that is related to the prevailing mistrust in the health care system of Black Americans and impacts seeking appropriate health care, noncompliance with treatment regimens, a lack of participation in research studies which compromises health status and health outcomes. This sentinel event which occurred in Tuskegee, Alabama, in Macon County, from 1932–1972, commands dialogue and magniloquence to conspiracy theories and underutilization of health care services in the 21st century for Black Americans. Fred D. Gray (1998), the civil rights attorney for the Negro men in the study, stated, “The government used 623 men as guinea pigs in a misguided 40 year medical experiment” (p. 14). Gray (1998) emphasized, “ The moral and ethical injury was compounded by the fact that all of these men were African American, predominantly poor and uneducated, and were deliberately kept in the dark about what was happening to them” (p. 14). The study sample included 399 Negro males with syphilis that was untreated and 201 presumed non-Syphilitic adults, who were at least 25 years of age.

A review of the literature revealed several studies have been conducted relative to the assessment of trust/mistrust in the health care system inclusive of: (a) Caterinicchio (1979), (b)

Throne and Robinson (1988), (c) Thom and Campbell (1997), (d) Thom et al. (1999), (e) LaVeist, Nickerson, and Bowie (2000),(f) Pearson and Raeke (2000), and (g) Hall et al. (2001). Brandon, Isaac and LaVeist (2005), during the months of July and August 2003, conducted a random sampling cross-sectional study utilizing a telephone survey of 277 African Americans and 101 Caucasian residents in Baltimore, Maryland concerning their levels of mistrust and underutilization of the health care system. The data collected from the Baltimore site were inclusive of a larger three city site, including New York City and Washington, District of Columbia (DC) with the focus on use of the health care system of minority group members. The Baltimore site focused on African Americans, partly due to the historical economical diversity and mostly segregated Black population, which prevented over sampling.

A series of questions from the cross-sectional survey also addressed knowledge of the USPHS Study of Untreated Syphilis in the Negro Male and underutilization of the health care system. An objective of the study conducted by Brandon, Isaac and LaVeist (2005) was to examine racial differences in the knowledge of the USPHS Study of Untreated Syphilis in the Negro Male and medical system mistrust. Findings from the study indicated knowledge of the USPHS Study of Untreated Syphilis in the Negro Male was not a predictor of trust of medical care. When reporting on the validation of the MMI which measures mistrust of health care organizations and examines the relationship between health care services underutilization and mistrust, LaVeist, Isaac and Williams (2009) confirmed,

> …patient mistrust is less focused on a specific individual or aspect of the care system. …it may be that mistrust emanating from patient experiences in one aspect of the health care system would lead to general mistrust of health care. This may explain why patients who have never participated in a clinical trial and therefore have no personal

> experience with clinical trials may be less willing to consent to participate when asked. They may have developed mistrust from other encounters with the health care system that leads to broader mistrust of other aspects of health care. (p. 2102)

While the legacy of USPHS Study of Untreated Syphilis in the Negro Male is credible, perhaps there lies a historical significance beyond USPHS Study of Untreated Syphilis which impacts trust/mistrust in the African American community (Gamble, 1997). Brandon, Isaac and LaVeist (2005) confirmed, "Rather, race differences in mistrust likely stem from broader historical and personal experiences" (p. 951). Brandon, Isaac and LaVeist (2005) theorized that healthcare underutilization of Black Americans impact health disparities and intersect with: (a) socioeconomics, (b) health care, (c) criminal justice, and (d) education.

These findings by LaVeist and colleagues parallel findings from the report, *Counties in Crisis Assessing Quality of Life in Alabama*. According to Vocino (2011),

> Throughout the state of Alabama there are alarming trends of poverty, crime, poor health and insufficient education. There are numerous examples of quality of life indicators in Alabama's counties that fall below those of Third World countries and a growing gap between areas that are performing well and their strained counterparts. (p. 44)

Hulbert, Armstrong, Gandy and Shaker (2006) found the increased significance of trust as a critical component of medical care. An expectation in patient-physician relationships is that a priority exists relative to the care and interest of the patient (Hall, Camacho, Dugan, & Balkrishnan 2002; Hall, Dugan Zheng, & Mishra, 2001; Hulbert et al., 2006; Thom, Hall, Stewart, & Luke, 1999). Kao et al. (1998) stated, "Trust is the cornerstone of the patient-physician relationship" (p. 1708). According to Brandon, Isaac and LaVeist (2005), the continuity associated with having a trusted health care provider evokes a long-term committed relationship, denoting familiarity, embracing the needs of the patient is lacking for many Americans. Gil (2004) elucidated,

> One of the most fundamental components of primary care is continuity of care. It is often assumed that continuity should have positive benefits to health care because of the accumulated knowledge and trust that develops between a patient and provider. (p. 65)

Brandon, Isaac and LaVeist (2005) posited the lack of trust as an enabling factor promotes limited access and a reduction of the quality of health care received by racial minorities. LaVeist, Isaac and Williams (2009) confirmed mistrust delays health care processes; in essence, one does not get the care needed in a timely manner, which can complicate beneficial and successful outcomes, thereby, impacting the progression of disease states and costs. LaVeist, Isaac and Williams (2009) stated,

> Moreover, as racial/ethnic minorities report more mistrust of health care, mistrust may be an explanation for disparities in health care utilization and adherence. And there may be race differences in the magnitude of the effect of medical mistrust on health services use. (p. 2102)

Hope is a force which reenergizes life, supports healing, facilitates coping and improves quality of life (Hendricks 1998a). It is postulated persons who exhibit a hopeful outlook are more likely to have greater trust in the health care system and ultimately attain a higher quality of life. Herth and Cutcliffe (2002) indicated, "…the assessment of hopefulness and its determinants is an important step in enhancing quality of life" (p. 1405). This study hypothesizes that persons who exhibit a hopeful outlook are more likely to have greater trust in the healthcare system, ultimately enjoying a higher quality of life satisfaction.

According to Stephenson (1991), "Hope has been implicated as a factor in maintaining and regaining health" (p. 1456). Trust in any relationship is essential to advancing commitments and sound futuristic choices. Hopefulness in the health care system could impact trust and advance life satisfaction preventing early mortality. Counties in the Black Belt in Alabama are in a state of crisis with long term problems relegated to the lack of equitable social goods and a historical and entrenched legacy of enduring violent structures, which continually impact health, education, socioeconomics and the criminal justice system for some social groups (Vocino, 2011). In addition, the health care system has failed to provide equitable care to all of its consumers, specifically to those of minority status—but critically so to the Black male, whose presence perpetuates a long standing historical and perpetual struggle in the milieu, in the Black Belt South and extending beyond the perimeter to the broader United States of America.

Statement of the Problem

White (2005) espoused, "The Tuskegee Study of Untreated Syphilis is an important issue in research, healthcare, ethics and race relations. The assumed consequences of knowledge of this study on the African-American community include mistrust of the healthcare system" (p.1566). LaVeist, Gaskin and Richard (2009) emphasized the need to understand the variables associated with unmet health care needs and the failure of not accessing the health care system in a timely manner, resulting in outcomes that are not positive, requiring care that is more costly, with poor health care outcomes and delays in diagnosis and treatment. Premature death can occur when access occurs at the tertiary level, with loss of actualized potential (Institute of Medicine, 2002).

The secretary of the U.S. Department of Health and Human Services (DHHS), Margaret Heckler, in January 1984, "established the Task Force on Black and Minority Health in response to the national paradox of steady improvement in overall health, with substantial inequities in the health of U.S. minorities" (CDC, MMWR,1986, p.109). The Task Force found "… longstanding disparities in the health status of Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans compared to Whites" (CDC, MMWR, 1986, p.109). Major initiatives which were federally mandated have been implemented, as measures to seek resolution to major health inequities of minority group members in comparison to their dominant group member counterparts. Key projects have been executed, beginning with the Negro Health Movement (1915–1951), which led to the establishment of the Office of Negro Health Work, by the U.S. Public Health Service (Thomas, 2001; Thomas et al., 2006). The Report of the Task Force on Black and Minority Health roused the DHHS in 1986 to establish the Office of Minority Health (OMH) with a mandate to implement recommendations of findings from the Task Force, also known as the Heckler Report. The mission of OMH "is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities" (U.S. Commission on Civil Rights, p. 7). In 1988, the CDC established the Associate Director of Minority Health, which in 2002 became the Office of Minority Health under the auspices of the CDC. In 2005, the Office of Minority Health and Health Disparities (OMHD) was established by the CDC in an attempt to advance health, quality of life and to eradicate health disparities for populations with health care vulnerabilities (Thomas, 2001; Thomas et al., 2006).

To attest to the entrenched and pervasiveness of health care disparities, and the need to close the health disparity gap, in 1990, the Office of Research on Minority Health (ORMH) was established by the National Institutes of Health (NIH). ORMH, in 2000, under the umbrella of the NIH, became the National Center on Minority Health and Health Disparities (NCMHD). Another mandate of NCMHD is to support and coordinate health disparity research programs with a specific emphasis on increasing the number of minority students who are underrepresented and encumber a background of association with health disparity groups. An over arching goal is to develop students who focus on biomedical and behavioral research. According to the U.S. Commission on Civil Rights (2010), the Sullivan Alliance to Transform America‘s Health Professions is a national effort to enhance health workforce diversity initiatives around the country. In January 2005, the Sullivan Alliance was organized to implement recommendations and findings of the Sullivan Commissions' landmark report, Missing Persons: Minorities in the Health Professions, presented in September, 2004, "and the Institute of Medicine Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce" (In the Nation‘s Compelling Interest Ensuring Diversity in the Healthcare Workforce, February, 2004, p. 3).

In 1979, Healthy People 2000 was published with consecutive publications of 2010 and 2020, in an effort to identify preventable disease threats, to reduce mortality, with goals and objectives targeting racial and ethnic populations. The elimination of health disparities was an overarching goal of Healthy People 2010, with goals of Healthy People 2020 to:

> (*a*) eliminate preventable disease, disability, injury, and premature death; (*b*) achieve health equity, eliminate disparities, and improve the health of all groups; (*c*) create social and physical environments that promote good health for all; and (*d*) promote healthy development and healthy behaviors across every stage of life. (Thomas, et al., p. 401)

Braveman et al. (2011) postulated, “Disparities in health and its determinants are the metric for assessing health equity, the principle underlying a commitment to reducing disparities in health and its determinants; health equity is social justice in health” (p. S150). Social scientists and medical ethicists have hailed the USPHS Study of Untreated Syphilis in the Negro Male as denoting injustice in the health care of Black American males. Health equity for Black males in the Black Belt was unjustly constructed. This unethical study impacted the community at-large, robbed wives and children of the victims of a healthy quality of life and continues to impact family members in multigenerational venues and social life. In exploring the phenomena of cause, it is necessary to view and frame the constructs of health equity. *As framed by Healthy People 2020, health equity* encompasses the attainment of the highest level of health for all people, “ … requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities” (Para 5). Thomas, Quinn, Butler, Fryer, and Garza (2011) postulated,

> Achieving health equity, driven by the elimination of health disparities, is a goal of Healthy People 2020. In recent decades, the improvement in health status has been remarkable for the U.S. population as a whole. However, racial and ethnic minority populations continue to lag behind whites with a quality of life diminished by illness from preventable chronic diseases and a life span cut short by premature death. (p. 399)

Due to the pervasiveness and inequity of the disparity in healthcare, people of color and others who appear in the lower tier of the social hierarchy, having less social status and goods are negatively and brutally impacted.

As a way of seeking clarification of the potential of clarity between the two constructs, of health equity and a health disparity from the perspective of a holistic framework, Healthy People 2020 defined a *health disparity* as, “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” (Para 6). Health disparities can evoke traumatic and limited agency to designated minority social groups in systematic ventures. The negativity experienced by groups who are not based on the pinnacle of the social hierarchy manifests a historical significance of deficits leading to “greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion” (Healthy People 2020, Para 5).

Disparities in health status have not shown evidence of equality since data has been collected and documented. Despite incredible advances, in the last 50 years, health status disparities in the United States have increased (Sankar, et al., 2007). The 1985 Minority Task Report found,

> That report—like its predecessors—documented significant progress: Americans were living longer, infant mortality had continued to decline—the overall American health picture showed almost uniform improvement. But, and that ‘but’ signaled a sad and significant fact; there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation’s population as a whole. (p. 11)

The significance of the disparity in health is essential to understand the pervasiveness and impact to the social lives of minority group members which are so devastated and the interrelationships which exists in interfacing American society. According to Williams and Jackson (2005),

> Racial disparities in health in the United States are substantial. The overall death rate for blacks today is comparable to the rate for whites thirty years ago, with about 100,000 black dying each year who would not died if the death rates were equivalent. (p. 325)

The Minority Task Force (1985) reported excess deaths contributed to the differences in health outcomes of minority group members relative to nonminority group members which differ substantially. Excess deaths are defined by the Minority Task Force (1985) as,

> … the difference between the number of deaths observed in minority populations and the number of deaths which would have been expected if the minority population had the same age and sex-specific death rate as the nonminority population. This method quantified the number of deaths that would not have occurred had mortality rates for minorities equaled those of non-minorities. (p. 3)

The excess death rate for minority members are significant in shortening life span, altering the actualization of potential, denoting a form of structural violence in systematic, systemic and institutionalized venues, impacting health equity (see Table 1).

Table 1

Average Annual Total and Excess Deaths in Blacks Selected Causes of Mortality, United States, 1979–1981

	Excess Deaths Males and Females Cumulative to Age 45		Excess Deaths Males and Females Cumulative to Age 70	
	Number	Percent	Number	Percent
Causes of Excess Death				
Heart Disease and Stroke	3,312	14.4	18,181	30.8
Homicide and Accidents	8,041	35.1	10,909	18.5
Cancer	874	3.8	8,118	13.8
Infant Mortality	6,178	26.9	6,178	10.5
Cirrhosis	1,121	4.9	2,154	3.7
Diabetes	223	1.0	1,850	3.1
Subtotal	19,749	86.1	47,390	80.4
All Other Causes	3,187	13.9	11,552	19.6
Total Excess Deaths	22,936	100.0	58,942	100.0
Total Deaths, All Causes	48,323		138,635	
Ratio of Excess Deaths to Total Deaths		47.4%		42.5%
Percent Contribution of Six Causes to Excess Death		86.1%		80.4%

Source: Report of the Secretary's Task Force on Black and Minority Health

Byrd and Clayton (2007) postulated,

> African Americans are experiencing – by far– the deepest and most numerous health disparities. However, other disadvantaged ethnic and racial groups such as Latinos – especially Puerto Ricans – Native Americans, Aleuts, native Pacific Islanders, and Asian immigrant groups such as Vietnamese, Laotians, and the Hmong also experience disparities. In addition, the list includes poor Whites, certain disabled and homeless groups, inhabitants of inner city ghettos and barrios, the elderly, and members of the gay/lesbian/bisexual/transsexual communities. (p. 11)

Mistrust in the health care system pervades centuries. Bloche (2001) posited,

> For many Black Americans, doubts about the trustworthiness of physicians and health care institutions spring from collective memory of the Tuskegee experiments and other abuses of black patients by largely white health professionals. This legacy of distrust, which, some argue, contributes to disparities in health care provision by discouraging Black Americans from seeking or consenting to state-of-the art medical services, is thus itself a byproduct of past racism. (p. 105)

The impact of the USPHS Study of Untreated Syphilis in the Male Negro does not afford a mere apology of wrong doing, but characterizes a time era and the significance of a people who generationally experienced years of chattel slavery, extreme poverty, the lack of a credible heritage in a foreign land, relegating as second class citizens and experiencing abuse in all areas of social life, altering the acquisition of equitable social goods. Byrd and Clayton (2001) clarified, “Racism in medicine and health care has paralleled racism in society. The nation’s health delivery system has been distorted by race and class problems from its beginnings” (p. 24S).

Structural violence prevents the accrual of social skills and goods, impacting the acceptance of Black Americans' to the privilege and status afforded members of the upper social tier, inclusive of the right to equitable health care. Cultural violence by far is a structure which imposes great detriment to people of color. H. Jack Geiger, in the foreword to Byrd and Clayton's (2002) volume of an American Health Dilemma; Race, Medicine, and Health Care in the United States, posited, "Slavery is America's original sin"… and "Racism is its chronic disease." To think of racism as a disease, similarly is a useful metaphor, is inadequate to define the reality of a moral outrage that is still, sadly, built into the very fabric of American society. Race and class, deeply confounded from the beginning, have been among the most powerful structural determinants of the American social order (p. xv).

Racism, according to LaVeist (2005), when conceptualized via the biopsychosocial model is a stressor. Racism defined by Clark, Anderson, Clark, and Williams (1999) is, "beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (p. 805). Williams, Neighbors and Jackson (2003) found after a literature review of fifty-three studies, a correlation between racism and health, with negative outcomes in mental, physical and behavioral health.

Bloche (2001) portrayed the historical significance and specificity of the negative treatment of minorities' experiences when interfacing the health care system. Bloche (2001) posited,

> In more intimate ways, minority patients' negative experiences with care providers can diminish their preferences for robust treatment and thereby engender racial disparities. Physicians' suspicions, stereotypes, negative expectations, and reduced empathy across racial lines can affect patients' feelings about their clinical relationships and thereby

> dampen patients' interest in vigorous diagnostic and therapeutic measures. Efforts to distinguish patient "preferences" from provider racial discrimination neglect the ways by which patients' negative responses to the latter can profoundly affect the former. (p.105)

LaVeist, Gaskin and Richard (2009) found through analysis of a study commissioned by the Joint Center for Political and Economic Studies and conducted by researchers from the University of Maryland and John Hopkins the astronomical costs associated with health inequities and racial disparities. The researchers examined both direct and indirect costs relative to the "provision of care to a sicker and more disadvantaged population" (p. 5). The following areas were explored: (a) premature death, (b) lost wages,(c) absenteeism,(d) family leave, and (e) productivity. Results of the study revealed,

> More than 30 percent of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities – more than $230 billion over a three year period. And when you add the indirect costs of these inequities over the same period, the tab comes to $1.24 trillion. (LaVeist, Gaskin & Richard, 2009, p. 5)

While the legacy of mistrust in the agency of healthcare of Black Americans transcends throughout the broader community, regardless of gender, the Black male contends with a problematic existence, presenting more vulnerabilities and a conglomerate of social deficits more so than any other member in American society. Braithwaite, Griffin and De La Rosa (2011) clearly distinguished the significance and value of the life of a Black American male in the 20th century and the malfeasance of the intent of the medical establishment in continuing, constructing and implementing the USPHS Study of Untreated Syphilis in the Negro Male. Braithwaite, Griffin and De La Rosa (2011) postulated,

> A continuing study question associated with the investigation was how it was possible for the researchers to justify their consciences that harming people for the sake of scientific knowledge was an acceptable practice. Perhaps that is the crux of the problem that we could face today. During the Tuskegee period, Negro males from rural Alabama—poor, uneducated, marginalized, disenfranchised—held little value in the eyes of the researchers. Their lives were cheap. Losing a few African American men for the sake of the advancement of scientific knowledge was worth the investment in the eyes of these investigators. This form of objectification of human lives was common among many individuals in the 1920s through the 1960s. It was not until whistleblowers across the nation began to evoke greater awareness of human rights violations against minorities that this targeted mayhem toward African American men was slowed. (p. 60)

To further substantiate the devastation experienced by Black males in the 21st century, Byrd et al. (2011) posited, “A recent report indicated that men of color are among the most understudied populations and that they suffer the poorest overall health outcomes” (p. 481). Black men are unduly burdened in all aspects of the undergirding associated with health care disparities. Low on power, educational attainment, socioeconomics and healthcare, impacting the criminal justice system at an alarming rate, the lack of occupational finesse due to stratification in the broader arena, the Black males’ existence defies a continuous and lifelong struggle in modern day America. Byrd et al. (2011) posited, “In addition, African American males continue to be less educated and more disenfranchised from the majority in society than Caucasian males and females and their African American female counterparts" (p. 480).

Ultimately, the sentinel event which occurred in Macon County, Alabama perhaps continues a perpetual legacy of mistrust, a cyclic lack of access to a compromised and inequitable health care system with varied social determinants, preventing full use to all consumers. Injustice in a healthcare marketplace has the potential to impact hope in a negative context which intersects with quality of life. Or, has a 40 year time period from the end of the study in 1972, November, allowed citizens in Alabama's Extended Black Belt an opportunity to heal, trust and garner hope in health equity and the inclusion to a rightful place of existence. An analysis of the variables, trust, hope, their influence and interrelationship on quality of life has the potential to produce new models of health care to a rural people in the Deep South expanding to the extended Black Belt of Alabama.

Purpose of the Study

Measuring levels of trust, perceived hope and significance to quality of life satisfaction in adults living in Alabama's Extended Black Belt can be instrumental in health care and quality of life model development. According to Thom, Hall and Pawlson (2004), measuring trust levels between provider and patient can uncover failings that are system wide or communication from an individual perspective. "Low levels of trust can be changed, and improved trust might well reduce disparities, increase access levels and improve health comes" (p. 124). Thom, Hall and Pawlson (2004) posited,

> Studies have found that lower interpersonal trust is associated with poorer care among patients of color. For example, in a large community study by Ann O'Malley and colleagues, trust in a personal physician was the strongest predictor of willingness to

> initiate antiretroviral treatment for HIV infection in a population of primarily African American and Hispanic inmates and was a strong predictor of preventive services use among African Americans. (p.127)

Thom, Hall and Pawlson (2004) provided credence to the saliency, dynamism and changeability of trust with results from qualitative studies suggesting that patient trust is a “state,” not a “trait”. Although, vaunted in the market place, trust is a fragile commodity with a unique set of vulnerabilities. If trust is not measured, ignored, nor cultivated, the ultimate demise of this rare commodity occurs. A person who trusts a provider is more likely to seek care, to comply with treatment recommendations and follow-up care. Preventive care is more likely to occur when one trusts a provider and the health care system. Overall the measurement of trust can inform health policy deliberation and provide a balance to the variable which threatens the relationship between doctors, patients and the healthcare system.

According to Synder (1995), “Hope is defined as the process of thinking about one's goals, along with the motivation to move toward (agency) and the ways to achieve (pathways) those goals” (p. 335). This study hypothesizes that persons who are hopeful exhibit a positive outlook and are more likely to have a greater trust in the health care system and enjoy a higher quality of life.

Significance of the Study

According to Byrd et al. (2011),

> Distrust of the medical community, inadequate education, low socioeconomic status, social deprivation, and underutilized primary health care services all contribute to disproportionate health and health care outcomes among Blacks compared Black Americans to their Caucasian counterparts. (p. 480)

In the state of Alabama, disparities exist in varied domains. Hegemony influences social determinants of health, education and socioeconomic status. In fact, the Alabama Health Disparities Status Report (2010) conveyed,

> Alabama has been ranked as one of the worst states in terms of health as compared to the nation for a number of years. Not only is the overall health poor in Alabama when compared to other states, but the health disparities between African Americans and Whites are considerable. (p. vi)

The National Health Care Disparities Report (2011) (NHDR), concluded, “All Americans should have equal access to high-quality care. Instead, we find that racial and ethnic poor people often face more barriers to care and receive poorer quality of care when they can get it” (p. 3). Mandated by Congress, NHDR identifies differences or lacunas in the health care of certain populations, inclusive of access to care and the quality of care comparative to certain groups. Findings have confirmed that inequities exist for subpopulation group members. Overall data confirms that disparities are indicative of many factors relative to differences in access, the consumption and quality of health literacy, bias of provider as well as poor communication between provider and consumer. The National Healthcare Quality Report (NHQR) tracks changes in the health care realm over a period of time (The Alabama Health Disparities Status Report, 2010).

Disparities and social determinants which intersect with inequity in the health care system are generational in context. Nelson (2002) found, “The sources of theses disparities are complex, are rooted in historic and contemporary inequities …” (p. 1). Due to intersections of race, socioeconomics, education, criminal justice and other social goods, which influence deficits in health care, ones’ agency can be impacted negatively throughout life. Disparities are grave and prevalent for people of color; structural violence prevents potentialities from becoming actualized. Structural violence, social location and other social determinants of health impedes the allocation and accrual of progressive social goods. Black communities and the people who reside therein can become counterproductive and as a result, the anomie and retreatism which presents in accordance to the ascribed veil of social acceptance, connecting to the materialist mindset prevalent in mainstream America.

Shariff et al. (2010) posited,

> Exposure to racism may increase stress and maladaptive coping behaviors such as smoking, alcohol use, or poor diet. Racism may also limit socioeconomic resources, reducing health care access and potential uptake of health-promoting behaviors. Additionally, racism may deter utilization of health care because of patient mistrust and negative experiences patients had during previous encounters. (p. 364)

The impact and reverberations of the USPHS Study of Untreated Syphilis in the Negro Male commands continued rhetoric, inhibiting praxis in its complete evolvement, which is thought by some scholars to prevent and alter essential and proper healthcare agency and solutions for people of a minority status. It has been debated by scholars that mistrust of a healthcare system which allowed the continuation of a study to occur over 40 years, presented a hindrance for Black Americans to receive proper and necessary treatment for a treatable and curable disease: syphilis. According to Riverby (2011), men in the 20–50 year age group were sicker, with death ensuing earlier than other age ranges. The lack of treatment shortened life spans to approximately 17 years in some instances specifically for men in the 20–50 age group. Nelson (2002) conveyed a large body of published research reveals that racial and ethnic minorities receive a lower quality of health services, and are less likely to receive even routine services than are White Americans. Relative to White Americans—and in some cases Hispanic—are less likely to receive appropriate cardiac medication (p. 2).

The importance of including minorities in research studies is necessary; the National Institutes of Health (NIH) mandates such inclusion on all grant submissions (Katz 2011; Pinn 2011). "A legislative mandate that women and minorities must be included in clinical research was incorporated into the language of the NIH Revitalization Act of 1993, providing statutory strength to the NIH requirements of inclusion" (Katz & Warren, 2011, p. 9). The requirements under the guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research in 1994 denoted the necessity of moving from exclusion to inclusion with specific requirements of: (a) ensuring that women and minority group members as well as their subpopulations be included "in all human subject research" and (b) Phase III clinical trials would ensure that minorities and women as well as their subpopulations "must be included that valid analysis of differences in intervention effect can be accomplished"(Katz & Warren, 2011, p. 9). While a mandate exists for inclusion of women and minorities, and although some scientists would argue over the necessity of such inclusion, given their view of the significance of biological or genetic evidence, of race/ethnicity, Pinn (2011) emphatically stated,

> The importance of overcoming any lingering negative legacy of the Tuskegee Legacy Study in generating distrust is this: Even though policies requiring inclusion now exist, if women and minorities do not agree to participate in research, then the intent of the policies cannot be fulfilled. (p. 9)

Byrd et al. (2011) conveyed the critical necessity for Black men to participate in clinical trials, "Results of clinical research on diseases that disproportionately affect African American males are often limited in their reliability due to common sampling errors existing in the majority of biomedical research studies and clinical trials" (p. 480). Black Americans in general participate incrementally less in biomedical studies than dominant population group members. Byrd et al. (2011) clarified, "Despite these governmental guidelines, African Americans of clinical trials and biomedical research relative to their share of disease burdens. Only 5% [percent] of the persons who participate in clinical trials are persons of color collectively" (p. 481). More specifically, Black males have failed to negotiate and participate in clinical trials at adequate levels (Byrd et al., 2011). The need for measurable outcomes is important to research findings. It is important to be able to generalize beyond the population studied.

According to The Centers for Disease Control Mortality Morbidity Weekly Report (CDC MMWR, 2011),

> Rates of preventable hospitalizations increase as incomes decrease. Data from the Agency for Healthcare Research and Quality indicate that eliminating these disparities would prevent approximately 1 million hospitalizations and save $6.7 billion in health-care costs each year. There also are large racial/ethnic disparities in preventable hospitalizations, with blacks experiencing a rate more than double that of whites. (p.1)

In a recent study, Byrd et al. (2011) found that across all ages, African American males, "continue to report a lack of trust as a primary reason for their unwillingness to participate in biomedical research" (p. 480). The significance of the lack of Black males' full participation in the health care arena is critical. Byrd et al. (2011) stated,

> There is an ongoing need to continue to seek advice, improve communication, and design research studies that garner trust and improve participation among African American males as a targeted underrepresented population. Such communication and

> dialogues should occur at all age levels of research development to assess current attitudes and behaviors of African American males around participation. (p. 480)

The reasons for the continued underrepresentation of Black males' full participation in the healthcare market place are varied. Factors include, "their common recollection and interpretation of relevant historical … biomedical events where minorities were abused or exposed to racial discrimination or racist provocation" (Byrd, 2011 et al., p. 480).

Byrd (2011) et al., further clarified distinct reasons for the allocated differences in disparities of the African American male in comparison to "others" and the need to find reasons for the lack of full participation in biomedical studies. Byrd et al. (2011) posited, "As such, understanding their perceptions, even in early developmental years, about health and obstacles to involvement in research is important" (p. 480).

Conceptual Framework

> Now faith is the substance of things [**hoped]** for, the evidence of things not seen.
> Hebrews 11:1 King James Bible (Cambridge Ed.)
>
> Now faith is the assurance that what we [**hope**] for will come about and the certainty that what we cannot see exists.
> Hebrews 11:1 International Standard Version (2008)

The Quality of Life, Hope and Trust Interrelationship Health Care Determinants Model is a mid-range theoretical framework model (see Figure 1) which guided this study. The model proposes that two concepts (trust and perceived hope) influence how individuals impact the health care system which can influence satisfaction of life. This model was deductively derived from the literature.

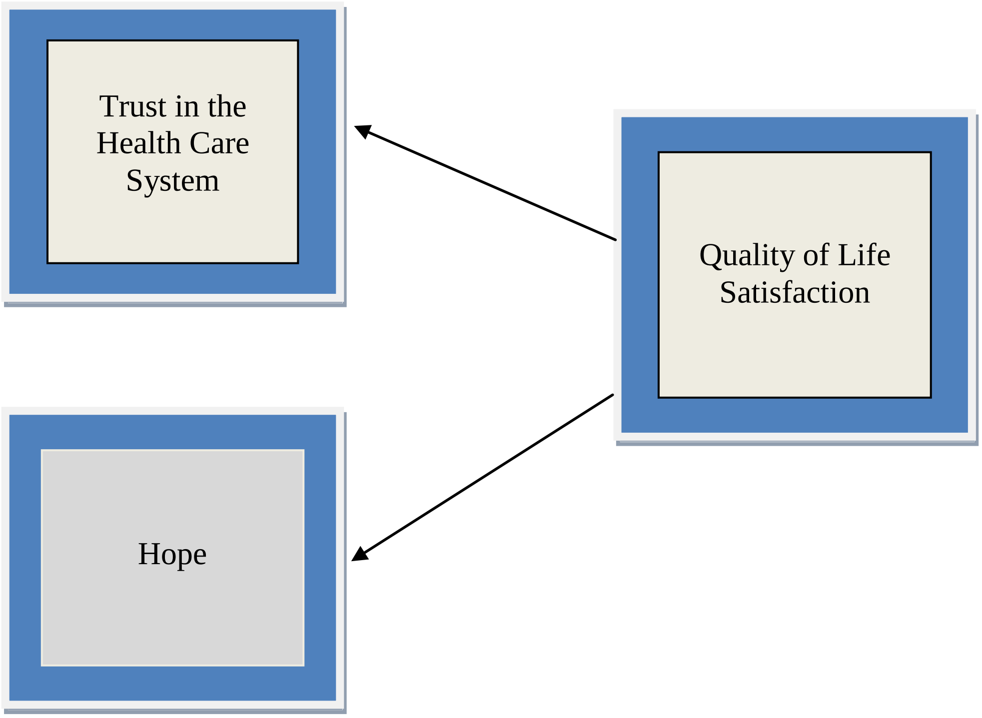


Figure 1. The Quality of Life, Hope and Trust Interrelationship Determinants Model

An exploration of the literature did not evidence the interrelationship of trust, the connection to hope and quality of life satisfaction relative to health care-utilization of residents in the extended Black Belt counties of Alabama. While varied studies have been conducted in the extended Black Belt area, the literature did not covertly uncover an exploration of the interrelationships and intersections of trust in the health care system and perceived hope to quality of life satisfaction, as is the crux and focus of this study.

There is a lacuna in the literature in this specific focus of scholarship. Research in direct connection to these concepts (i.e. trust, hope and quality of life) and their interrelationships were not revealed during a review of the literature. LaVeist, Isaac and Williams (2009) conveyed, “There has been the lack of a generalized measure of mistrust in health care that is suitable for inclusion in both patient-based and community studies" (p. 2094). While scholarship has increased in recent years relative to Trust theory, a primary focus is on health care providers, health promotion and illness prevention and not the health care system in totality (LaVeist, Isaac & Williams, 2009). It is noteworthy that specific studies have been conducted relative to mistrust of Black Americans in reference to the USPHS Study of Untreated Syphilis in the Negro Male; however, the essence of the uniqueness of the extended Black Belt area to this study's significance was not completely uncovered while exploring and fleshing out the literature. A faith-based community sample for surveying and measurement of the concepts of trust, hope and quality of life, were not evident in the review of literature.

The results of the data from this study will extend knowledge reflective of the healthcare agency of residents in a depressed area, influenced by the legacy of a sentinel event which occurred over 70 years ago and assess new knowledge relative to trust, hope and quality of life of residents in the Black Belt South in the southeastern region of Alabama.

Hope provides one with a sense of courage to confront life circumstances and a capacity to deal with issues that promote a negative context. Hope is unique to the individual (Groopman, 2004). Measuring levels of perceived hope and the significance to quality of life satisfaction relative to health care behavior is significant to the framework for this study.

Trust

The significance of trust on intrinsic and instrumental grounds is significant (Hall, Dugan, Zheng et al., 2001; Rhodes & Strain, 2000). Boyas and Valera (2011) posited, "Trust is a psychological element that supplies the patient-provider relationship with value, importance, and substance" (p. 144). Intrinsically trust enhances a relationship and is important to the substance of a relationship such as love or friendship in an intimate relationship (Hall, Dugan, Zheng et al., 2001). Interestingly, Boyas and Valera (2011) found through a review of the literature, the influence of trust by socioeconomic factors such as income and education, although, these factors are not always proven to positively correlated. Medical ethics requires a preservation, enhancement and justification of trust which is a fundamental premise of healthcare law and policy. According to Caldwell, Davis and Devine (2009) "… trust is ultimately the relinquishing of one's personal choice or power in the expectant hope that another party will honor the elements of the social contract between the parties" (p.104).

Caldwell, Davis and Devine (2009) posited,

> To trust is to affirmatively invest one's actions in the belief that another person or party is essentially good, and assumes a world view that votes for optimism and hope within a world that has not always merited that confidence. (p. 109)

According to Halbert, Armstrong, et al. (2006), trust is important in the relationship of patient and providers of care. While some prior research studies show that Black Americans report lower levels of trust in health care providers, in comparison to European Americans, information is limited on the various factors which are associated with trust. Low trust may be linked with racial concordance of providers. Interpersonal skills of providers allow the receivers of care to believe that physicians are acting in their best interest either in a positive or negative context. Trust levels build over time incrementally; individuals with less frequent health care visits might have low levels of trust in providers of care. Understanding perceptions of trust can allow specific aspects of the health care to be addressed and how structural factors inhibit use of the health care system (Halbert, Armstrong, et al., 2006). Thom, Hall and Pawlson (2004), indicated the significance of trust in health care research, which denoted, "If we do not measure levels of trust, we can ignore it, fail to cultivate it, and ultimately lose it" (p.124). Measuring levels of trust between patient and provider can reveal systemic problems inclusive of communication which is non-therapeutic. Thom, Hall and Pawlson (2004) indicated, "low levels of trust can be changed, and improved trust might well reduce disparities, increase access, and improve health outcomes" (p. 124).

The definitions of trust in the literature are varied in conceptualization. Trust was conceptualized by Meize-Grochowski (1980) as encompassing, "an attitude bound to time and space in which one relies with confidence on someone or something. Trust is further characterized by its fragility" (p. 567). Caldwell, Davis and Devine (2008) conveyed, "Trust within a secular or organizational context is much like the concept of faith within a religious framework" (p. 103). Caldwell, Davis and Devine (2009), posited in comparison to faith, individuals asked to trust, or likewise demonstrate faith, could possibly struggle to maintain a commitment to others due to the possibility of betrayal.

Johns (1996) postulated trust as a, "willingness to place oneself in a relationship that established or increased vulnerability with reliance upon someone or something to perform as expected" (p. 81). Lynn-sMcHale and Deatrick (2000) conveyed trust as, "…a process, consisting of varying levels, that evolves over time and is based on mutual intention, reciprocity and expectations" (p.17). Trust, according to Hupcey, Penrod and Mitchum (2001),

> … emerges from the identification of a need that cannot be met without the assistance of another and some assessment of the risk involved in relying on the other to meet this need. Trust is the willing dependence on another's actions, but is limited to the area of need and is subject to overt and covert testing. The outcome of trust is an evaluation of the congruence between expectations of the trusted person and actions (p.290).

According to Mayor, Davis and Schoorman (2011),

> Kee and Knox (1970) argued that to appropriately study trust there must be some meaningful incentives at stake and that the trustor must be cognizant of the risk involved. The definition of *trust* …is *the willingness of* a party *to be vulnerable to the actions of* another party *based on the expectation that the* other *will* perform a particular *action important to the* trustor, *irrespective of the ability to* monitor or *control* that other party. This definition of trust is applicable to a relationship with another identifiable party who is perceived to act and react with volition toward the trustor. (p.712)

Models of trust have evolved over time through varied conceptualizations of scholarship. Hupcey and Miller's (2006) purview of a model of trust by Throne and Robinson (1988) as moving through three stages which include: (a) naïve trust, (b) disenchantment, and (c) guarded alliance (p.1133). Another model of trust reviewed by Hupcey and Miller (2006) was developed by Trojan and Yonge in 1999. The model of trust developed by Trojan and Yong (1999) situated trust as evolving through four phases over time consistent with: (a) initial trusting, (b) connecting, (c) negotiating, and (d) helping (p.1133). Caldwell, Davis and Devine (2008) postulated, "The hoped for benefits sought after in the creation of trust-based social contracts require a commitment and investment on the part of the persons being asked to trust" (p. 109). Corbie-Smith (1999), portrayed trust as specific to outcomes garnered from a physician/patient relationship. Corbie-Smith (1999) conveyed,

> Without a sense of trust in their doctor, some patients might be reluctant to participate in a clinical trial. For these patients, an established clinical relationship, and the open communication it fosters, may be a necessary preclude to the discussion of risks and benefits in research. Unfortunately, as political and economic constraints increasingly

> limit the clinical interaction, a trusting relationship may take longer to develop, if it develops at all. (p. 7)

A Nurse and Intrinsic Trust

Having trust in health care providers is essential to the development of rapport. In an analysis of the type of trust garnered from Nurse Eunice Rivers, the "Negro" nurse who was hired to assist with the logistics of the USPHS Study of Untreated Syphilis in the Male Negro, intrinsic and interpersonal trust was exemplified by the men for Ms. Rivers. Nurse Rivers conveyed a sense of loyalty and benevolence to the men in the study. Mayer, Davis, and Schoorman (1995) conveyed,

> Benevolence is the extent to which a trustee is believed to want to do good to the trustor…. Benevolence suggests that the trustee has some specific attachment to the trustor. An example of this attachment is the relationship between a mentor (trustee) and a protégé (trustor). The mentor wants to help the protégé, even though the mentor is not required to be helpful, and there is no extrinsic reward for the mentor. Benevolence is the perception of a positive orientation of the trustee toward the trustor. (p. 719)

In the afore-referenced conceptualization of benevolence, an extension occurs to another with a sense of esteem, providing an altruistic persona. A sense of satisfaction and loyalty is derivative from the social contract. Mayer, Davis, and Schoorman (1995) conveyed, *interpersonal trust* "as an expectancy held by an individual or a group that the word, promise, verbal or written statement of another individual or group can be relied upon" (p. 712).

Albeit, there are debatable issues of Ms. Rivers' controversial role in the study, Paris (2012) conveyed,

> …She was a trusted friend to all of the men. Nurse Eunice Rivers was recommended by Dr. Dibble to serve in the study and was given the title *scientific assistant*. Her task was to keep in touch with the men throughout the study, to assemble them for examinations and drive them to and from the examination location. She was needed because the racism of the day did not allow white nurses to attend black patients. Yet, the term 'patient' is a misnomer in this circumstance because the purpose of the study was not to treat the men but to study the progress of their disease until death when the results of autopsies would finally determine the impact of the disease on the bodies of the men. (p.14)

The significance of trust has been established in medical relationships. Trust is attributed to having an intrinsic value and is critical regarding how individuals seek health care. Trust is critical to patients' willingness to seek care, provides information unique to their circumstances, how they present for treatment, and follow physicians' recommendations. Interpersonal trust differentiates the boundaries of a relationship between two individuals and is exclusive to a doctor–patient relationship, whereas, systems, general, social, or institutional trust, characterize attitudinal domains of collective entities or social organizations. Interprofessional trust denotes specifics to a known institution, a hospital, health care plan and from a broader perspective of a social or professional system (Goold, 2002; Hall, Camacho, Dugan, & Balkrishnan, 2002; Mechanic, 1998; Rousseau et al., 1998). Trust is an integral component in medical treatment relationships and bears a fundamental premise to the development and growth of doctor/patient interactions. Trust impacts various areas including preventive care, adherence, and a commitment to following prescribed regimens.

Paris (2012) further substantiates the role that Nurse Rivers maintained in trying to procure all medical aspects of care given the situation. Paris (2012) postulated,

> Living in an environment where most poor illiterate black men could never afford medical treatment, it is easy to see why she would view medical examinations along with some treatment as a tangible benefit for the men. That was confirmed by the willingness of the men to cooperate with the study, their delight in the car trips to and from examinations, the free lunches on the day of the exams, their visits to the Tuskegee campus and the great relief in having burial insurance. Clearly, she believed unquestionably in the goodness of her work and the benefits it provided for the men. The genuine friendships that developed between her and the men were sustained for the rest of their lives. She visited them in their homes, ate at their tables, cared for them when they were sick, comforted them on their death beds, attended their funerals, and explained to their families the benefit of granting permission for autopsies. (p. 15)

The integral and central role of trust in medical relationships is valued and substantiated. Trust is endemic to interrelationships which makes living in a civil society possible. It is paramount in all phases of a relationship. In the health care setting, trust garners significance in the foundational phases of the relationship, albeit with physicians, nurses, agencies and the health care system in totality (LaVeist, 2008). Due to the vulnerability of patients when encountering nuances associated with the health care system, an inherent appearance of being defenseless and helpless regarding medical encounters can ensue. Trust, rapport and commitment in relationships are essential to healthy growth and survival. In an analysis of the relationship of Nurse Eunice Rivers Laurie (Nurse Rivers' maiden name) to the men in the study, Paris (2012) perceived that Nurse Rivers conveyed the essence of trust and commitment to the men in the study; in a broader context this intrinsic trust typifies trust of a nurse to patients in a long-term relationship. Paris (2012) espoused,

> Nurse Rivers knew the men well because she and they lived in the same community. She also knew how to deal with white doctors and on at least one occasion she interceded with a white doctor by telling him that if he did not stop disrespecting the men they might withdraw from the study. The doctors viewed the men as mere subjects of study. Nurse Rivers viewed them also as patients for whom she exercised the art of caring. (p.15)

The meaning of trust to Nurse Rivers for the men in the USPHS Study of Untreated Syphilis in the Male Negro is one of emphatic compassion, while some will debate her role ethically, her trust, devotion, and commitment to her patients' remains exemplar to a nurse-patient relationship in the context of the epoch. While there is increasing dialogue about Nurse Rivers' role and the power to stop the study and provide the men with treatment, Paris (2012) posited, "The doctors did the harm by deceiving the men about their diagnosis not Rivers. They are the ones who refused treatment; not she" (p. 18).

Nurse Rivers' position historically in the power structure projected the agency of which she could assume, what she could do in provoking positive care to the men in the study, she did without question (Paris, 2012). Paris (2012) surmised,

> As a nursing teacher at Tuskegee and a public health nurse she knew that the men were not being treated for syphilis. Nonetheless, she believed that they were receiving a measure of medical care that they would not be receiving otherwise. (p. 16)

Epochal periods are what they are in specificity, agency dictates from a cultural vantage and from political hegemonic interrelations and intersection. Jones (2011) provided an alternative lens of which to view Nurse Rivers, as he characterizes her role in the study and the last words she voiced to him in their last encounter. Jones (2011) stated,

> When the moment came to say good-bye and leave, I mentioned her attempts to discuss the mistakes that haunted her, apologized for the interruptions and asked her to tell me what she thought they had done wrong. For what seemed like an eternity Nurse Rivers sat there in silence. When she spoke, her reply was voice heart-wrenching. Voice laden with emotion, lower lip quivering, struggling to maintain her composure, she cast her head down, closed her eyes, and sobbed, 'Oh, Dr. Jones. We should have told the men they had syphilis, and God knows we should have treated them.' (p. 26)

While Jones' portrayal of Rivers is one of manifesting power in a structure, perhaps a better analysis encompasses a consideration of historical specificity. Given the hierarchical structure of which Nurse Rivers attained, she had no power except subservience to the paternalistic white male dominancy, in this specific circumstance, the USPHS physicians. Calhoun (1995) speaks to the need to be "attentive to problems of cultural difference". Calhoun (1995) posited, "The issue of historical specificity arises at all levels of analysis. It also includes all time periods" (p. 86). One's position in history relegates to the specificity that is assumed in the context of the times lived. Calhoun (1995) posited, "…to grasp social life in something of its fullest [there is a] need to be attentive to cultural difference and historical specificity" (p.72). Human action denotes understanding not in isolation of the agents and the agenetic processes assumed, but in the broader context of the social world and order that an agent is forced to reside (Calhoun, 1995). Calhoun (1995) espoused, race and gender "…need to be seen as socio-cultural organization of roles and identities, not simple derivations from the alleged facts of biology" (p. 76). Calhoun's (1995) perception of specificity regarding gender is critical, acknowledging "… we live in a deeply gendered world" (p. 76).

The issue for Nurse Rivers was not from a lack of trust for and to the men in the study, nor was she unethical in her approach, but rather, an operative function occurred from the power structure assumed, given the dynamics of social relationships in the 20th century. The low power in the structure of the role of any nurse to a physician, given the epochal period, promoted subservience; however, a realization has to be clearly embraced—Nurse Eunice Rivers was a Black nurse. There exists a need for trust from a multiplicity of institutional entities and providers which are encountered in health care settings. Patients must trust that providers of care will deliver ethically safe and competent care, having their highest regard at heart during health care delivery.

Sullivan (2004) surmised,

> The ability of the patient to trust his or her provider is integral to the development of a good patient-provider relationship. Trust strongly influences key aspects of care delivery, including communication, patient adherence to treatment, and patient satisfaction. Evidence shows that minority patients are more trusting of minority practitioners and may tend to be less trusting of white providers. Distrust can worsen a patient's care by impairing the therapeutic relationship between patient and provider. (p. 23)

Hope

Braithwaite (2004) provided an analysis on the essential elements of Hope and the theoretical framework of the concept which is grounded in the field of positive psychology. Braithwaite (2004) postulated,

> Hope theory provides a blueprint for how we might use hope to improve our well-being. Developed in the context of psychological work on stress and helplessness and their adverse effects on mental health, hope theory makes a significant contribution to teaching us to live more positive lives.… (p. 131)

According to Braithwaite (2004), “Hope theory assumes mastery, almost domination, on the part of the individual in the way he or she engages with the world” (p. 131). Braithwaite (2004), postulated,

> Hope theory for individuals, therefore, poses three challenges—articulating our goals, identifying the routes or pathways that we can use to achieve these goals, and finding our personal sense of agency. Agency refers to a self-perception that we can move along the pathway to goal achievement—we have the willpower to start something and to persevere in the goal journey. If our hope lacks “legs” in any of these regards, it is reduced in stature as a human resource for change, reduced to wishful thinking, or daydreaming, or escapism. (pp. 130–131)

Hope is necessary to understand the themes and intricacies which encompass the study of social issues (Braithwaite, 2004). Power and governance are inclusive to the role of the social scientist. Caldwell, Davis and Devine (2008) postulated a perspective of hopefulness on life allows a fortress to, “buffer us from the verities of a world in which harm, damage, violations of principles, selfishness, and greed are ubiquitous” despite the presence of negative factors in the world” (p. 109).

The concept of hope bears critical reflection and denotes philosophical rhetoric. McGeer (2008) posited,

> … even though trust can and does feed our hopes, it is our empowering capacity to hope that significantly underwrites our capacity to trust, that both provides its motivational energy and makes rational the extension of our trust in epistemically challenging circumstances. (p. 237)

Smedley (1998) conveyed the critical need to assess the impact which hopelessness manifests on the victims of disenfranchised social group members and has a whole on the agency and impact of generational transmission. Smedley (1998) posited,

> Too few people have studied the phenomenon of the transgenerational retention and transmission of an ethos of hopelessness. But some filmmakers have documented the heartbreaking stories of black men and women who suffered unbearable discrimination in our nation's industries. And others have told the painful stories of the hopelessness suffered by so many on Indian reservations. Their sons and daughters felt their pain and the degradation they have experienced. We need to study this phenomenon and to understand what these kinds of experiences have done to the self-image and self-esteem of low-status minorities. (p. 698)

According to Eliott and Oliver (2009), an interest in hope in the medical arena was garnered in the 20th century, more specifically during the latter period. A consensus occurred that hope is essential and of value to humanity. Furthermore, having hope is essential to well-being, increases treatment compliance, is positively correlated with and contributes to an improved quality to life satisfaction and promotes longevity (Cheavens, et al.2006; Herth & Cutcliffe, 2002; Duggleby et al., 2012; Eliott & Oliver, 2002, 2007, 2009; Farran et al., 1995; Good et al. 1990; Gordon & Daugherty, 2003; Hendricks, 1993; Herth, 1995; Herth & Popovich, 1995; Stephenson, 1991). It is essential that health care workers encourage, foster, protect, consider, maintain, increase and instill hope in health care clients and consumers (Begley & Blackwood, 2000; Cheavens et al., 2006; Eliott & Oliver, 2009; Gordon & Daughtery, 2003; Herth & Cutliff, 2002; Kodish & Post, 1995; Orne, 1968; Sokol, 2006).

Hope does not exist in isolative contexts, but centers on various realms of social life. Religious hope was identified by two terminally ill patients in a study by Eliott and Oliver (2009), as referencing God as the source, and connecting hope as continuing past life in this universe; in essence, hope was centered on altruism for family members, with a continued meaning and purpose for the individual. The theme of religious hope connected with the past, present and the future directly connecting to an omnipresence and omnipotent essence. The essence of hope in this case was situated with the totality of life and the life cycle with one of complete generativity with an intact ego, as the life cycle was completed (Erikson, 1964). Hope presents a connection to humanity through a hierarchical religious efficacy, extending beyond this life, with an enduring tangible effect of being hopeful with and for others; hope in this instance was operationalized as being infinite. Hope was significantly framed as necessary to endure adversities associated with living, and through adversities, hope remains as living ensues (Eliott & Oliver, 2009).

Western conceptualizations of hope most often focus on Erikson (1964), specifically from a psychosocial perspective. Erick Erickson operationalized hope as being epigenetically central to human psychosocial development. Frankl (1942) encompassed the necessity of hope to life and the significance to persistence in adversity in spite of obstacles. Frankl (1942) who endured inhumane suffering in Nazi Concentration Camps, thereby losing his family understood deeply with the pertinacious resolve of hope, encompassing, “He who has a ‘Why’ to live for can bear almost any ‘How’” (p. ix). Frankl’s lived experiences evoke that tragedies and challenges can become defeatable with hope and positive energy.

According to Miller (2000), “hope means anticipating success, yet, having some uncertainty” (p. 523). Studies reflect on the significance of hope to life satisfaction, to live in spite of negative odds, which counters the essence of a broken spirit. Destitute individuals living mostly below the poverty level, with marginality associated with existence and presence with low educational attainment and achievement and low SES, can become apathetic and hopeless. Hope has the capacity to be life sustaining, in essence taking the worst circumstance and embracing the verve and sinew to continue despite the difficulties encountered (Lazarus, 1999).

Hope is essential for survival. Farran, Herth and Popovich (1995) stated, “Hope constitutes an essential experience of the human condition. It functions as a way of feeling, a way of thinking, a way of behaving and a way of relating to one’s self and one’s world” (p. 6). Farran, Herth and Popovich (1995) referenced a dynamic and optimistic view of a hopeful perspective and indicated, “Hope has the ability to be fluid in its expectations, and in the event that the desired object or outcome does not occur, hope can still be present” (p. 6). Hendricks et al. (2005) posited the persona of hope serves as a buffer to physiological and psychological defenses. The absence of hope correlates to an early demise relative to functioning.

In a qualitative study by Herth (1990) of terminally ill patients with 6 months or less to live, seven categories of life-fostering principles of hope were identified, inclusive of: (a) interpersonal connectedness, (b) attainable aims, (c) spiritual base, (d) personable attributes, (e) light-heartedness, (f) uplifting memories, and (g) affirmation. An analysis revealed, three of the seven categories persisted during the end of the life cycle, which included a spiritual base, interpersonal connectedness and attainable aims. According to Herth (1990), a common theme from the Hope study centered on “caring relationships”, which should be fostered in all health care relationships (p. 1258).

In essence, hope appears to be an anticipation of something good to come which may or may not be realized. Being hopeful evokes an anticipation of a future that is good and is based upon mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, and a sense of “the possible” (Miller, 1992).

Nekolaichuk, Jevne and Maguire (1999) embraced the concept of hope from a holistic perspective with three dimensions: (a) personal, (b) situational, and (c) interpersonal (Cutliffe & Herth 2002). Cousins (1974) maintained that hope engenders a renewal process of restoration of confidence in themselves, their government and the future. Hope is “generated by the ongoing for something better … which gives human beings a sense of destination and the energy to get started” (p. 5). Parrington (1997) connoted the spirit of hope ratiocinating, “he that lives in hope danceth without music” (p.41).

The concept of hope is important to one’s being, and effective to one’s rational state of mind. The fundamental nature of hope is to lighten burdens and to lift spirits. According to Hendricks et al. (1995) the absence of hope or hopelessness, does not equate to critical reflection, praxis does not occur. However, hopefulness allows one to become energized, alleviating despondency and despair, aids in healing and creates positive expectations for an enjoyable future. Hope gives life to a devastated and broken spirit. According to Fitzgerald (1979), hope is “fundamental to human life as food and water (p. 17).

Hope is specific to the restoration of a civil society in American life. President Barack Obama (2008) asserted in the *Audacity of Hope*,

> That was the best of the American spirit, I thought—having the audacity to believe despite all the evidence to the contrary that we could restore a sense of community to a nation torn by conflict; the gall to believe that despite personal setbacks, the loss of a job or an illness in the family of a childhood mired in poverty, we had some control – and therefore responsibility—over own fate. (p. 356)

Kubler Ross (1969) conducted studies on patients who were coming to the end of the life cycle. A central focus of Kubler Ross' studies centered on completion of the life cycle; in essence, individuals would no longer maintain a physical presence in the world, but were coming to the end of life as known. Although, according to Kubler Ross (1969), these individuals could not consider the conceptualization of hope as a cure for their illness, but, hope centered on: (a) less pain or a lack of pain, (b) a death of encumbering peace with dignity, and (c) having hope in the essence of hope. Ross (1969) posited, "If a patient stops expressing hope, it is usually a sign of imminent death" (p.140).

Hope transcends disciplines. The field of psychoneuroimmunology (PNI) embraces the concept of hope and optimism as being significant to attitudinal significance impacting bodily processes and functioning. Townsend (2012) reflected on hope and optimism as evoking physiological changes which impacted healthy immune system functioning. When the perception that when one's individual milieu lacked support systems or significance in genres of relating to the environment, despondency occurred, which mirrored the perceived loss of hope.

Groopman (2004) delved further into other physiological responses of hope, thereby postulated, belief and expectation—the key elements of hope—can block pain by releasing the brain's endorphins and enkephalins, mimicking the effects of morphine. In some cases, hope can also have important effects on fundamental physiological products like respiration, circulation, and motor function. (p.xvi)

Miceli and Castelfranchi (2010) conveyed, "…hope remains a resource of invaluable importance. Suffice to consider that as long as there is hope, unfulfillment and actual frustration are relatively easy to endure" (p. 271).

A necessary and essential exploration of the concept of hope is paramount to a wholistic view of the conceptualization. Miceli and Castelfranchi (2010) cautioned that positive hope is not always beneficial or inherent to inspiring successful motives. Miceli and Castelfranchi (2010) exclaimed,

> …we do not claim that hope always fosters one's motivation to strive for the hoped for outcome. Hope may even restrain motivation, and this risk is intrinsic to its very nature. In fact, hope might favor a *passive waiting* for the desired outcome to "spontaneously" obtain. (p. 269)

In this passivity, a lack of propulsive behavior is not actualized. In essence positive outcomes are not derived, a violent act ensues to prevent potentialities of optimistic outcomes.

Hope must be viewed from varied lens to provide an objective perspective and analysis. It is imperative to impart Hope, as an attribute is not always positive. Miceli and Castelfranchi (2010) equated,

> Despite all of those positive implications, hope may have some drawbacks. To start with, when hope is maintained despite a negative expectation, there might be some cost

> implied: the possible (albeit cautious) waste of resources. Second, under certain conditions (typical of passive hope), hope favors the mere waiting for the hoped-for event, and possibly only the virtual satisfaction of one's own wishes. Third, hope *might* favor some self-deceiving attitude or inaccurate perception of reality. However, we endorse the view that accuracy is *compatible* with a hopeful attitude (McGeer, 2004; Pettit, 2004). Hope represents a sort of shield against the negative consequences implied by uncertainty about the future—premature discouragement and disengagement from pursuit—by favoring a view of success as plausible, and motivating to strive for it. But "plausible" can still be distinguished from either "probable" or "certain." (p. 270)

Hopelessness

It is useful in reviewing the concept of hope to discuss the construct of hopelessness and the significance on the impact on life and living. Miceli and Castelfranchi (2010) posited, **"…**hopelessness can be conceived of as the worst human condition. If there is no possible anticipation of a better future, there is no meaningful future and little reason to live as well" (p. 271). According to Merriam-Webster (2012), hopelessness is framed from the following definitions: "(a) having no expectation of good or success, despairing, (*b)* not susceptible to remedy or cure, (*c)* incapable of redemption or improvement, (d) giving no ground for hope, desperate, *(e)* incapable of solution, management, or accomplishment, impossible" (http://www.merriam-webster.com/dictionary/hopeless, Para 1).

Dunn (2005) posited hopelessness encompasses: (a) despondency, (b) forlornness, (c) lack of actualization, (d) incurableness, (e) desperation, and (f) uncorrectable situations. Farran, Herth and Popovin (1995) and Marsiglia, Kulis, Perez and Bermudez-Parsai (2011) in contrast asserted the conceptualization of hopelessness as being characterized by emotions from a negative context; indicative to a pessimistic agency with a sense of anhedonia and a sense of loss of futuristic goal accomplishment. According to Marsiglia, Kulis, Perez and Bermudez-Parsai (2011), pessimistic individuals are at greater risk for developing hopelessness, which connotes a negative impact on psychological and health related behaviors. In a longitudinal study in Finland with a sample of 2,428 middle-aged men conducted by Everson et al. (1966) when hypertensive risk factors were controlled, individuals with high hopelessness were at greater risk for developing hypertension. In fact, the study conveyed that the odds were three times higher than in hopeful individuals.

During an initial assessment by Everson et al.'s (1966) findings revealed that with high levels of hopelessness in men, death was most likely to occur than for men who presented with moderate or low levels of hopelessness, even when controlling for socioeconomic, biological and behavioral risk factors. According to Dunn (2005), levels of increased hopelessness have also predicted a prospective diagnosis of hypertension, myocardial infarction and cancer.

Gender is significant and specific to one's hopeful attitude. Marsiglia, et al. (2011) related, in the general population, hopelessness was higher for men. Spatial location and demographics were relative to one's state of hopelessness. Men who come from a rural background, are single, divorced, have less education, and are fairly poor, exhibit more hopelessness than their female counterparts. The long-term effects of hopelessness can lead to a depressive state and engulfs a pervasive sense of powerlessness and helplessness, agency is rendered useless, suicidal ideations can lead to demise. Anomie and oppression can lead to a sense of hopelessness. Braithwaite (2004) conveyed, "Like all social phenomena, hope can go very wrong" as it did for the poor illiterate farmers who sought perceived health care in the 1930's, seeing a physician was something that these men had not been privileged (p. 6). The anticipation for hope and trust was not to be realized from the medical establishment for the men in the pseudoexperimental study.

According to Young et al. (1996), "… it is important to recognize that hopelessness is dynamic, not static: The intensity of hopelessness not only varies from person to person, but varies within a single person across time" (p. 156). Beck and colleagues (1990) imparted hopelessness, "… may be seen as having both state and trait characteristics" (p. 194).

Young et al. (1996), signified, "…hopelessness is regarded as a state variable that varies over time. The intensity of hopelessness in any given person at any particular time will be explained by both stable individual differences (traits) and changing conditions (other state variables)" (p.156).

Rosenfeld et al. (2011) confirmed, in an epidemiological study done by Anda et al. in 1993 with 2,832 of adult sample participants in the US ages 45–77 found there was a 1.6-fold increase for moderate to severe hopelessness for an increased risk of fatal ischemic heart disease even when other known risk factors and demographic variables were controlled.

According to Young et al. (1996) in a study conducted by Watson, Morris, and Hood (1988) from a sample of Christians that were not psychiatrically screened, that feelings of sin and grace interacted in affecting hopelessness. However, the worldview of non-Christians could be entirely different. Perhaps, there would be an increase in hopelessness associated in depressive states. Studies in the area need to be done for clarification regarding the significance of hopelessness in non religious participants encumbering the previously referenced concepts. Rosenfeld et al. (2011), indicated that Levine (2000), characterized hopelessness as an "*embittered, dark state*" with the possibility of leading feelings associated with despair and emptiness. Sullivan's (2003) conceptualization of hopelessness arises from oncoming grief which is more anticipatory as in the inevitableness of one’s death (Rosenfeld et al., 2011). While, in some instances, hopelessness is conceptualized as the loss of or absence of hope, in uniquely other circumstances a conceptualization of the concept is viewed as a loss of goals or aspirations (Rosenfeld et al., 2011).

Dunn (2005) posited, from psychology literature that hopelessness can be viewed as a state or a trait. Individuals with trait hopelessness manifests outcome expectancies with associated negativity relative to varied aspects of life. Those with state hopelessness have limited outcome expectancies of negativity. Individuals with trait hopelessness are actually more susceptible to state hopelessness.

Assessing and measuring hopelessness can provide insight into depressive states to a vulnerable people, viewed as second class citizens, often, not experiencing the level of health care as dominant members in society. Hall and Flores (2011) clearly distinguished the difference between trust and hope,

> Whereas trust involves the construction of positive expectations in the midst of uncertainty, hope is able to facilitate action even when the likelihood of positive outcomes may seem distinctly remote. Hope thus enables agency through the concomitant existence of a positive vision alongside mistrust and probable failure. In its positive form, hope is a valuable means of bringing about emancipation and better futures. (p. 64)

The significance and essence of hopefulness to the fullest extent was evident from the men in1932 in the USPHS Tuskegee Study of Untreated Syphilis from a collective vantage, quintessentially, a collective agency ensued relative to the possibly of receiving health care. For the men, the USPHS Syphilis Study of the Negro Male, the expectation of hope in a health care system in the rural south, experienced a collective hope as gone wrong. The specificity of the time era cannot be negated. Byrd and Clayton (2000) postulated,

> The stubborn and persistence of the race—and class-based health system conundrum can be explained on the basis of a medical-social culture hundreds of years old that is heavily laden and burdened by race and class problems compounding continued social and economic deprivation. (p. xxiv)

The Significance of Hope in a Faith-Based Community

The Essence of a Faith-Based Community for a Historically Oppressed People

The population sample in this study was derived from a faith-based community. Hope, faith and worship are central to the existence to the survival of the Black soul. A people whose ancestry includes a conundrum of oppression and violence seek to survive a devastation of "otherness", encumbering a loss of visibility, decreased self-value and self-worth, rendered from an abusive enslavement and lineage of domination.

Ramsey (2012), in a personal communication with Dr. R.U. Ferguson, reflected on the rich, unique and spirited style of worship of the Black church which clarified the central premise of the essence and centrality of need and purpose for the Black church as an institution. Ramsey (2012) indicated, "The Black Church was born to fill the spiritual needs of former and present Negro slaves of that time who were in some cases denied worship privileges in mainstream churches" (p. 51). At the end of the 17th century, freed slaves were able to establish a worship body of Black parishioners. With the abolition of slavery, Black Americans were able to embrace cultural and spiritual traditions, blending principles of Christianity with spirited praise and worship (Gale Encyclopedia of Public Health, 2012). Warren (2011) posited, “culture and religion, particularly among African Americans, are interwoven and interdependent and cannot be separated” (p.142). According to Paris (1985),

> …black churches have always had a profound concern for the bitter and painful realities for black existence in America as well as an abiding hope in a bright and radiant future (eschaton) free from any form of racial injustice. The latter hope designates the locus of ultimate value where all people are in harmony with the transcendent holy and supreme God of the Judeo-Christian faith. Traditionally, the black churches have interpreted human life, including all of its suffering and pain, in accordance with that ultimate goal of which they have never lost faith. The convergence of that sacred principle with their efforts for improved temporal conditions reveals the integral relationship of religion and politics in the black church. (p. 2)

The Black church provided a medium for the landscape in America to endure social and political transformation (Ramsey, 2012). The “Church” in the Black community during the civil rights era provided a haven for a downtrodden people to meet and strategize for the birth of a world-altering movement. Ramsey (2012) articulated, “It transported the last, the least, and the left out from the murky waters of Jim Crow laws to the high seas of freedom and respectability” (p. 51). Providing an essence of acceptance is proverbial to ownership and is endemic for Black parishioners. The Black church maintains a power structure and ownership exclusive to a Black people (Ramsey, 2012).

The Black Church as a Liberator for an Oppressed People

Ramsey (2012) conveyed, “The Black church has not only contributed to the metamorphosis of the lives of … [Black Americans] … but has also been a catalyst of change and betterment for all voiceless and disenfranchised peoples of the world” (p. 54). Ramsey

(2012) voiced, “History verifies and supports the premise that the [B]lack church has served as an effective voice crying in the wilderness on behalf of the powerless Negro…” (p. 54). “…The Negro found himself caught in the clutches of confinement by discrimination and the Jim Crow laws of segregation” (p. 54). Ramsey (2012) articulated, “The [B]lack church has played a significant role on the stage of human history” (p. 50).

Mueller, Plevak and Rummans (2001), contended, “Religion and spirituality are among the most important cultural factors that give structure and meaning to human values, behaviors, and experiences” (p.1225). Awara and Faseys’ (2008) philosophic conjectures encompassed beliefs of values and illness behaviors that are shaped by religious and spiritual dimensions which intersect with cultural behavior. The significance of the elements of faith, hope and compassion in the healing process are now embraced more by physician and patients. King (1967) conveyed that spirituality involves a search for reality’ and is a core concept of religion as well as philosophy. More in-depth, King (1967) clarified that spirituality encompassed a sense of: (a) transcendence of one’s usual mode of experience and perception, (b) falling short or acknowledging imperfection of an ethical or moral principle, (c) togetherness or being united with others, and (d) a search for meaning.

Mueller, Plevak and Rummans (2001) further distinctly contrasted religion and spirituality. The word *religion* is from the Latin *religare*, which means “to bind together.” A religion organizes the collective spiritual experiences of a group of people into a system of beliefs and practices. *Religious involvement* or *religiosity* refers to the degree of participation in or adherence to the beliefs and practices of an organized religion. *Spirituality* is from the Latin *spiritualitas*, which means “breath.” It is a broader concept than religion and is primarily a dynamic, personal, and experiential process. Features of spirituality include quest for meaning and purpose, transcendence (i.e., the sense that being human is more than simple material existence), connectedness (e.g., with others, nature, or the divine), and values (e.g., love, compassion, and justice). Even though some people who regard themselves as spiritual do not endorse a formal religion, religious involvement and spirituality are overlapping concepts. Experientially, both may involve a search for meaning and purpose, transcendence, connectedness, and values. In this light, religious involvement is similar to spirituality. Spirituality may also have communal or group expression; when this expression is formalized, spirituality is more like an organized religion (p. 1225). From a perspective of denomination, Black Americans are majority Protestant. Historically, many embrace worship in the Black church, where the overseer is more than naught Black, as well as a majority of the congregants. The Pew Foundation U.S. Religious Survey in 2008 found Black Americans are the most religious ethnic group in America. For Black Americans, the largest Protestant denomination is Baptist, which primarily comprise four factions, with the two largest being the National Baptist Convention USA and the National Baptist Convention of America.

The Black church traditionally provides a place of safety and security, solidarity, extending trust— is a safe haven—and offers a venue of survival against the harsh realities of living in the Western world to a group who share a common ancestry and ethnicity. Encumbering a sense of fellowship to the parishioners within its boundaries exudes a common significance to an oppressed people. The Black church was observed by Olansky, Simpson, and Schuman (1954), as “the center of social functions in the rural Negro community” when referencing the environmental factors of the men in the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male (p. 695).

The Centrality of Worship to the Black Soul

Dubois (1899/1973) documented the significance of the Black church in a community that was central to the survival of its Black parishioners,

> The Negro church is the peculiar and characteristic product of the transplanted African, and deserves especial study. As a social group the Negro church may be said to have antedated the Negro family on American soil; as such it has preserved, on the one hand, many functions of tribal organization, and on the other hand, many of the family functions. Its tribal functions are shown in its religious activity, its social authority and general guiding and coordinating work; its family functions are shown by the fact that the church is a center of social life and intercourse; acts as newspaper and intelligence bureau, is the center of amusements—indeed, is the world in which the Negro moves and acts. (p. 17)

Historically, the Black church has and continues to serve as a haven for “socialization, inspiration, communication, training, and healing” and contributes significantly to the complete development of people in the community extending beyond its walls, sometimes becoming a family surrogate (Bagley & Caroll, 1998, p. 117; Brown, 2008; Taylor et al., 2008). In essence, the Black church is the cradle of protection and affords a spiritual renewal to a people who are and remain as a whole ingrained in an oppressive realization of marginalization. The significance and impact of such strong supportive networks positively impacts quality of life, often buttressing the often harsh realities of an imperfect world for a minority people. Mattis, Fontenot, Hatcher-Kay, Grayman and Beale (2004) articulated,

> Theologians assert that themes of hope and optimism are especially salient in African American theology—particularly in Black liberation theology. African Americans have

> cultivated particular traditions of Biblical interpretation that metaphorically link Black oppression to the oppression suffered by Biblical Israel. In this interpretative scheme, God is seen as the ultimate ally of the oppressed. Moreover, the lives of Biblical figures are read as testaments to God's power to transform the destinies of those who have been forced to endure adversity and injustice. In sum, African American theological traditions endeavor to reinforce in believers a conviction that struggles are not without meaning and that God has the power to achieve extraordinary things even in the lives of those who are oppressed and marginalized. (p. 7)

According to Brown (2008), "Outside of the family, Black Americans create bonds with individuals in the community and churches that also become integral components of their social support networks" (p. 35). In many Black communities the churches are second only to the family as an important social institution (Taylor & Chatters, 1988). Historically, African American families have relied on their churches to contribute to the psychoeducational development of their children and provide them with additional role models (Franklin, Boyd-Franklin, & Draper, 2002). The church serves as a place for "socialization, inspiration, communication, training, and healing" (Bagley & Caroll, 1998, p. 117). Having these special individuals in the community may serve to create a powerful support system for Black Americans. The historical relevance and significance of the Black church metaphorically, exudes a paternalistic presence which transcends a spiritual essence to the holistic nature of human survival. According to Mueller, Plevak and Rummans (2001), "Most studies have shown that religious involvement and spirituality are associated with better health outcomes including greater longevity and health-related quality of life (even during terminal illness) and less anxiety, depression and suicide" (p. 1225). The Black preacher is often held in high esteem, connecting to the spiritual and psychosocial needs of the parishioners under his *watch*; is rooted in the community of the parishioners' he serves , and maintains a wealth of multigenerational knowledge. The powerful position of the Black preacher in the local church and the community bears significance and relevance to his involvement in the provision of the psychosocial and health care needs of the congregation. The Black preacher is pivotal to the congregations' varied needs with the inclusion of the requirements of maintaining a healthy lifestyle, seeking to enhance a higher quality of life satisfaction.

The Black church has been a protective and political liberator, very visible in this perspective in the 1950s and 1960s, expressing a stern opposition to racism and mobilizing the civil rights movement, in the cradle of the confederacy. In fact, some actors in the Saint (St.) Mark Missionary Baptist Church membership were directly involved in the Civil Rights movement, making a significant contribution to social illegalities to a *still enslaved* people, shackled with horrific injustices.

Traditionally, religiosity in the south from the perspective of a worship and a social venue connects to historical and social movements specifically when two races intersect, one the oppressed and the other the oppressor, denoting a strong division of Black Americans and European Americans. The use of religion particularly in the 1950s and 1960s in some southern Caucasian congregations theoretically and physically embraced segregationist institutional principles justifying inferiority and control of Black Americans (Henderson, Phillips & Will, 2005). Nelson (1971) captured the political movement and structural institution in the Black church in the following context,

> The extent of the shift in the base of black leadership from the white to the black community is illustrated in a remark made by one minister. When asked if he felt that

> he, as a “man of God,” should really be involved in the civil rights movement, he responded that, first, he did feel so and, second, if he were not, his congregation would dismiss him. In terms of followership, this represents significant change from a time when, if a black minister did get “out of hand” and would not bow to white authority, that authority might well convince the congregation to either control or fire him. (p. 356)

Social movements are not isolative in their impact and significance, the community in totality is impacted from a global perspective in its spheres and intersections. The harshness received from dominant group members in the US for an existence of “Blackness” is situated in the broader lived experiences of an oppressed people. In the Black community the church connotes an immense power base in the historical lives of the residents with the shadow of generational chattel status from dominant members in America. Paris (1985) posited, “As the existence of slavery revealed, social systems that are shaped by racism aim at total annihilation” (p. 4).

The Significance of Faith and Hope for Black Parishioners

The significance of faith in the lived lives of an oppressed people is of significance when one references hope as a pivotal influence for change. “Individuals who regularly attend church may experience greater exposure to … messages of hope” (Mattis, Fontenot, Hatcher-Kay, Grayman & Beale, 2007, p. 191). From a biblical perspective, the essence of faith and hope yields a comparative analysis, “Now faith is the substance of things hoped for, the evidence of things not seen” (Hebrews 11:1, KJV). The essence of structural components of quality of life for an oppressed people often stems from an enrichment and participation of agency in a faith based context. The hope for a brighter future, a better day and manifesting faith that it will come to pass are situated from varied perspectives. Mattis, Fontenot, Hatcher-Kay, Grayman and Beale (2007) posited, "…African American theology developed in a sociopolitical context marked by oppression … as a consequence, … has had to address itself …[in]the need to deliver hope to those who have few compelling reasons to be hopeful…" (p. 201).

On August 28, 1963, Dr. Martin Luther King, Jr. at the Lincoln Memorial in Washington, DC, delivered a powerful address which sustains great historical significance, connecting hope and faith. King (1963) stated:

> This is our [**hope]**, and this is the faith that I go back to the South with. With this faith, we will be able to hew out of the mountain of despair a stone of **[hope].** With this faith, we will be able to transform the jangling discords of our nation into a beautiful symphony of brotherhood. With this faith, we will be able to work together, to pray together, to struggle together, to go to jail together, to stand up for freedom together, knowing that we will be free one day. (p.5)

According to Townsend (2012), "Faith is thought of as the acceptance of a belief in the absence of physical or empirical evidence" in comparison, "hope is a special kind of expectation" (p. 121). Faith requires transcendence above the physical world; hope transcends negativity, no matter the direness of a situation or circumstance and acts as an energizing force, focusing on the positive, facilitating coping, promoting healing and enhancing life quality (Townsend, 2012).

Caldwell, Davis and Devine (2008) viewed faith,

> … as the behaviors and actions of an individual to relinquish one's personal choices and power to God in the expectant hope that those actions will demonstrate that individual's

> willingness to comply with God's will for that individual. This faith is based upon each person's individualized knowledge and interpretation of God's laws and teachings which gives that person a vision of life's meaning and that provides clarity about what one believes that God expects from him or her. (p.103)

Caldwell, Davis and Devine (2008) embraced faith from the perspective of Fowler (1995), "…being able to let go and accept the trials and hardships of life is an act of profound character that demonstrates an acknowledgement that God has more to teach us in the process of self-renewal and growth" (p. 111).

The essence of faith and hope sustains an assurance to the quest of first class citizenship to an oppressed people. Distinct lines of separatism continually exist for the most part in the Black Belt south for the Anglo and Black American people in religion and worship. Hegemonic processes from the broader community prevent equitable living, altering health care equality; the Black church sustains a paternalistic presence for a people who are burdened evoking a sense of listlessness and lassitude from the harshness of a lack of equality of social relationships and goods. The significance of Jim Crowism is felt by the vulnerable, which can include the perceived powerful in the Black community in the Deep South. The USPHS Tuskegee Study of Untreated Syphilis in the Negro Male is an exemplar of ethical violations in the health care delivery system. The men, their wives and children were not offered treatment for a treatable disease.

Quality of Life Satisfaction

Quality of life (QOL) is subjective and unique to the individual including facets of life which are both negative and positive, which makes it a multi-dimensional concept. Veenhoven (1996) posited, "Currently, the term 'quality of life' denotes two meanings: (1) the presence of conditions deemed necessary for a good life, and (2) the practice of good living as such" (p. 3). Quality of life can be assessed at the individual, community, country levels or in a specified social group. Veenhoven (1996) articulated,

> At the individual level, the term quality of life can take on both meanings. When we say that somebody doesn't have a good life, we may mean that he/she lacks things deemed indispensable and/or that this person does not thrive. These conditions may coincide, but this is not necessarily the case. A person can be rich, powerful and popular, but still be troubled. On the other hand, someone who is poor, powerless and isolated, may nevertheless be thriving both mentally and physically. … these variants [are]-respectively: *'presumed' quality of life* and *'apparent' quality of life*. Life-satisfaction is one of the indicators of 'apparent' quality of life. Together with indicators of mental and physical health, it indicates how well people thrive. Data about life-satisfaction is used for several purposes. (p. 3)

Quality of life is broad in scope and views an "individuals' physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationships to salient features of the environment" (The WHOQOL Group, 1995, p. 1405). Rapaport, Clary, Fayyad and Endicott (2005) conveyed,

> Quality of life has been defined in a number of ways, and many measures exist for assessing the construct. Most definitions explicitly state that the assessment of quality of life should take into account patients' subjective views of their life circumstances. This includes perceptions of social relationships; physical health; functioning in daily activities and work; economic status; and an overall sense of well-being. While measures of functioning focus on objective, quantifiable impairments that exist,

> measures of quality of life assess enjoyment and life satisfaction associated with various activities. (p. 1171)

Philosophical concepts and definitions of Quality of Life encompass many perspectives. Lehman (1996) simply defined quality of life as, "…patients' perspectives on what they have, how they are doing, and how they feel about their life circumstances" (p. 78). The fundamental nature of QOL entails a subjective sense of well-being, a quality functional status, and the ability to access needed resources and positive goal accomplishment (Lehman 1996). From Lehman's (1996) perspective, QOL also includes variables associated with personal characteristics, inclusive of sex and age, income satisfaction and a global sense of well-being. In comparison, the World Health Organization (WHO), according to Orley et al. (1998), perceived QOL as, "concern[ing] itself primarily with affective states, positive and negative impacting both material and social worlds of an individual" (p. 291).

Orley et al. (1998) described QOL as being influenced by what is happening 'out there', but it is coloured by the subjects' earlier experiences, their mental state, their personality and their expectations" (Orley et al., 1998, p. 291). Basu(2004) conveyed on the construct of quality of life in a statement by Sir Robert Platt. Basu (2004) stated,

> To quote Sir Robert Platt at the Linacre Lecture … (Platt, 1963), postulated"…How often, indeed, do we physicians omit to enquire about the facts of happiness and unhappiness in our patients' lives." Yet all this is just as much the live fabric of medicine as biochemistry and applied physiology. (p. 36)

The significance of life quality satisfaction is significant, to individuals overall health differentials, particularly so, in being cognizant of the disparity in healthcare, socioeconomics, education and criminal justice for disenfranchised minority groups in comparison to Northern

European American counterparts. The CDC (2007) related QOL as one's (individual or group) perception of mental and physical health over increments of time. Interestingly, providers of health care utilize the construct in measuring the long term effects of chronic illness and the impact on day-to-day activities. The United States Department of Health and Human Services (DDHS) Healthy People 2010 initiative embraced the following conceptualization of QOL:

> QOL reflects a general sense of happiness and satisfaction with our lives and environment. General quality of life encompasses all aspects of life, including health, recreation, culture, rights, values, beliefs, aspirations, and the conditions that support a life containing these elements. More specifically, health-related QOL reflects a personal sense of physical and mental health and the ability to react to the factors in the physical and social environments. (p. 10)

Satisfaction in life and the quality sustained allow opportunities for certain individuals and groups that others may lack.

According to the Kirwan Institute (2011),

> …"opportunity structures" lead to stability and personal advancement in our society. These opportunity structures include high-performing schools, affordable housing, sustainable employment, safety from crime, environmentally safe neighborhoods, home equity and wealth, access to affordable health care, and others. Together, these structures form a system—a "web of opportunity"—and a person's location within this web significantly influences that individual's chances for happiness and success in life. (p. 3)

The growing significance of QOL influences research and is a growing body of knowledge. A link exists correlating the knowledge of providers of care in relevance to patients treated and the impact of detecting and acting on negative changes in health status (Minick & Harvey, 2003; Pipe, Kelly, LeBrun et al., 2008).

Subjective well being and quality of life or life satisfaction is often used synonymously in the literature. The perspective of subjective well-being embraces both theoretical and empirical contexts providing an evaluation of an interpretation of the essence of life (Diener & Diener, 1995; Tovar-Murray, 2010). From a theoretical perspective, happiness is subjective, framed from a personal perspective of what makes life good (Syzmanski, 2000; Tovar-Murray, 2010). As a theoretical construct, subjectivity of well-being embraces facets of life satisfaction and one's positive affect (Deiner et al., 1995; Tovar-Murray, 2010).

The affectional component consists of a balance of feelings from positive and negative feelings; experiences can be described as transient and emotional. In contrast, the cognitive domain embraces life satisfaction and is global in assessment of positive life appraisals (Diener, Emmons, Larsen & Griffin, 1985; Tovar-Murray, 2010). One's current emotional and mental state is reflective of a present state of being evoking mental and emotional states. One's state of happiness is personal and relative to positive thoughts (Tovar-Murray, 2010).

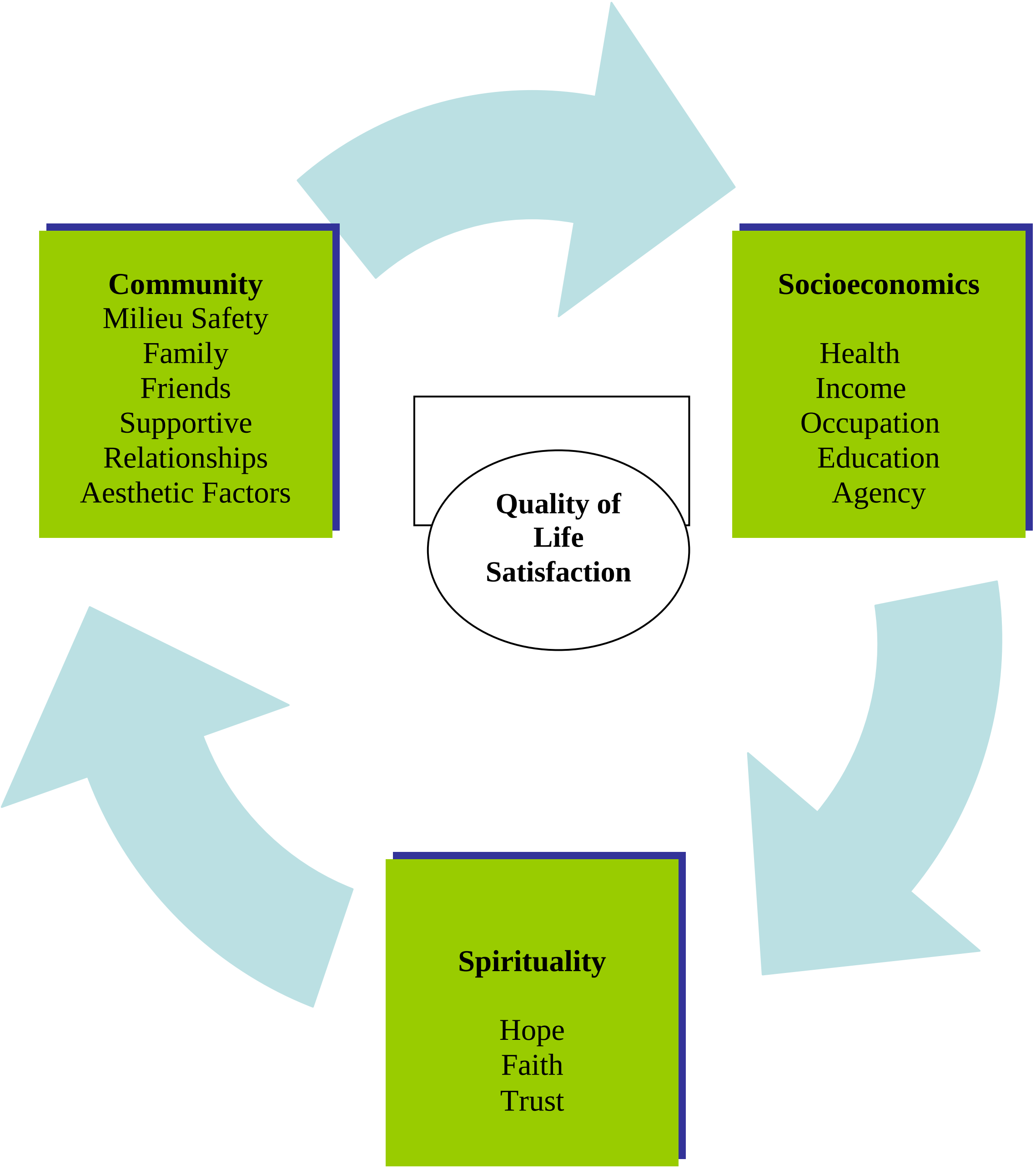


Figure 2. Lett's Faith-Based Quality of Life Model

From an African American perspective, early research on subjective well-being conveyed attributes which are socially ascribed and encompasses the psychology behind mood and mental states (Tovar-Murray, 2010). From a preponderance of the literature in a study by

Taylor, Chatters, Hardison, and Riley in 2001 found between income and subjective well-being a negative relationship but a positive relationship occurred between education and subjective well-being. A study by Diener, Scollon and Lucas(2003) showed a paradoxical effect relative to differences in gender with women reporting subjective happiness on the same level as their male counterparts, while yet reporting more emotions in a negative context. Ehrich (1973) revealed from a past research study that Black Americans who were married had more contentment with life circumstance than those counterparts who were unmarried (Tovar-Murray, 2010).

Poor health care stifles growth and productivity, a lack of hope hinders a positive agency, evoking despondency and apathy leading to a poor quality of life satisfaction. Trust in any relationship is essential to advancing commitments and sound futuristic choices. Hopefulness in the health care system could impact trust and advance life satisfaction.

The Patient Protection and Affordable Care Act (P.L. 111-148), signed into law on March 23, 2010 by President Barak Obama with the Health Care and Education Reconciliation Act (P.L. 111-152), is representative of many changes to occur in the health care system. In fact, the legislation is extensive in scope and is representative of the most expansive health care innovations “since the 1965 creation of the Medicare and Medicaid programs” (IOM, 2011, p. 2). However, the new legislation leaves the current market based model intact while tightening some regulations of the insurance industries (NESRI, 2010).

P.L. 111-148 will provide access to an additional 32 million Americans who were previously uninsured (IOM, 2011). However, universal health care is not an option; thereby all of Americans’ citizenry will not be insured. NESRI (2010) conveyed, “[There is] no universal guarantee of access to health care, and 23 million people will remain uninsured. A majority of the uninsured are likely to be lower income, among which people of color are overrepresented" (p. 2). NESRI (2010) further clarified deficits of inequity of P.L. 111-148:

> Our assessment finds that the law fails to protect and fulfill the human right to health care for people of color. Although the law greatly improves access to Medicaid for people of color who are poor, those with lower to middle incomes will likely struggle to afford meaningful coverage that they can use to get comprehensive care. The level and quality of care will continue to depend on how much a person can pay, where they live and whether they are employed, among other factors, thus perpetuating health care disparities. (p. 1)

The values of which a society espouses and ascribes become relevant to the needs of citizenry of the disadvantaged, the poor and marginal. Brown and Flores (2011) postulated,

> Whether or not a society upholds the proposition that universal health care should be a right available to all its members, for example, and whether it manages to crystallize this proposition into institutions, is to a significant extent an outcome of the value-commitments that define such society... (p. 65)

NESRI (2010) posited,

> As the provisions of the new law are not required to have a positive effect on reducing health disparities, many measures are bound to fail people of color. In contrast, a health system that works for everyone would be based on the principle of equity. (p. 3)

The Black Belt South in the 21st Century

According to Allen-Smith,Wimberely and Morris (2000),

> A product of the 1700s and 1800s, the Black Belt is quite discernible even today. The historic Black Belt did not disappear with the rural and southern outmigrations of the

> early and mid-twentieth century. Neither did its poor conditions go away with the coming of New South prosperity in urban areas or with technological advances and social programs. (p. 323)

Reflecting on the previously depiction of the Black Belt described by Wimberley (2000), Zekeri (1996) exemplified, in an analysis of a community in a rural Black Belt county, that residents manifest deficits in various contexts associated with economic well-being and life quality, inclusive of soaring poverty rates, limited growth of jobs, increased out-migration and per capita income which continues to fall. Race-based inequities hinder~~s~~ collective communication and interactions; from an ecological basis, with existing commonalities generalizing to rural Black Belt communities. In some instances there are miles and miles of barren land with replicas of physical structures and landmarks associated with the 18th and 19th centuries. Gibson (1941) conveyed, “The plantation system of cotton culture proved an appropriate adjustment to Nature’s resources in early days, and upon this adjustment has evolved a culture even more individualistic than is the soil upon which it rests” (p. 1).

Zekeri (1996) stated, “The community has not been hospitable to Black Americans because they are seen as social inferiors and this view is expressed by many Whites who grew up in the community” (p. 204). Zekeri (1996) conveyed, established community relationships and hegemonic forces are static and unchanged and is embraced by hierarchical dominant group majority members of the community. Black Americans, even with political power lack resources with established community networks, and thus the Black Belt area essentially remains unchanged. According to Bliss, Howze, Teeter, and Bailey (1993),

> During the 1970s and 1980s, African-Americans came to play increasingly important roles in local government. However, this success was achieved at the high price of

> polarizing the white and African-American populations in community after community in the Black Belt. The combination of drastically different life chances and social clan conditions, combined with recent conflict over political enfranchisement and school desegregation, has divided the Black Belt in a manner which seriously limits the ability of communities in the region to address problems of the future. African Americans and Whites in this region live separate social lives. On a personal level, relationships often have qualities of warmth (perhaps tinged with paternalism and dependency), but as social collectivities the races are divided by distrust. (p. 222)

Hare (2010) in an editorial from the Montgomery Advertiser posited, “But the economic woes that have held back the rural counties of the Black Belt for more than a century remain stubbornly entrenched” …(Para 3).

In relating to the Governors of Alabama and their work in the Black Belt, Hare (2010) stated, “None of them came close to bringing the Black Belt counties up to the economic level of the rest of Alabama” (Para 1). According to Hare (2010), “Huge problems remain” significantly higher unemployment continues in comparison to the rest of Alabama which averages 9.7 percent. In July of 2010 unemployment rates for 12 Black Belt counties revealed the following percentages: (a) Bullock 14.2, (b) Choctow11.4, (c) Dallas18.3, (d) Greene 19, (e) Hale 12.3, (f) Lowndes 16, (g) Macon 11.7, (h) Marengo 12.9, (i) Perry 16.5, (j) Pickens 11.7, (k) Sumter 14.9, and (l) Wilcox 21.9. Poverty rates in each of the 12 counties also surpasses the state average of 15.9 percent and are reflective of the following percentages: (a) Bullock 36.6, (b) Choctaw 22.9, (c) Dallas 29.9, (d) Greene 30.3, (e) Hale 26, (f) Lowndes 25.4, (g) Macon 30.5, (h) Marengo 22.6, (i) Perry 31.7, (j) Pickens 25.6, (k) Sumter 32.9, and (l) Wilcox 30.2 (Hare, 2010).

Theoretical Framework

“Injustice anywhere is a threat to justice everywhere.”

Dr. Martin Luther King, *Letter from the Birmingham Jail*

The review of literature disclosed the following theoretical conceptualizations which will provide a framework for exploration of the major variables in this study and are inclusive of: (a) public health critical race praxis (PHCR), (b) structural violence, (c) anomie, (d) domination, and (e) critical race theory. A hermeneutics approach is useful; it is necessary when interpreting the intricacies of social systems and actions, to understand the operative functions of rules, roles and norms of complex social situations, in essence, a relation of the parts to the whole is necessary (Feinberg & Soltis, 1998). The under pinning of complex social arrangements and an analysis of the interactions and interpretation of actors, populations, systems, customs and mores are essential to policy development. According to Ho (2007), structural violence, while it may not directly implicate the actor of violence, as outlined by Galtung (1969), exposes a clear logic behind the systemic nature of how violence is distributed.

Whitkin and Gottschalk (1988) conveyed,

> Social science and its products are infused with moral and political assumptions. As such science can be used to provide ‘objective truth status’ to dominant societal beliefs, or to increase awareness of the processes by which knowledge is created and validated. … Critical reflexive theory has a liberating potential because it attempts to expose unquestioned, inherited truth, and proposes alternative conceptualizations. (p. 218)

Chambon, Irving and Epstein (1999) provided further insight into the role and guise of a social scientist,

> …the task of the theorist is not always to offer sensible guidance on the conduct of practice but to test and challenge…theory should be radical, probing and immoderate, it is when we allow our thinking to be fearless, to encounter philosophical extremities, that we have the best chance if understanding the world at a deep level. (p. xiv)

Ford and Airhihenhuwa (2010) commented on the critical need for a just and fair society and the primacy of critical theory in this venture. Ford and Airhihenhuwa (2010) posited,

> A primary objective of critical theory is to evaluate and advocate for justice and fairness in society. This kind of evaluation seeks a balance between the descriptive methods typified in the utopian reach of socio-political philosophy and the explanatory methods typified in some of the uncritical premises of the social sciences. (p. 1395)

Theoretical constructs of critical theory are necessary frameworks and provide a lens to review inequities and disparities commencing the agency of people of color and the poor, in relation to their noted lack of equitable social goods, social location and an inequitable power base in comparison to members of the dominant group. A focus of critical theories is to emancipate, in this interest, would serve to review ideologies of social conventions which are embedded into the fabric of society, in essence, their existence are implied.

Praxis is critical in areas of associated systemic institutions. A way of existence can seem natural and without detrimental cause unless reflection and action occurs. Developing a "critical consciousness" commands a level of growth and immersion. In fact, personal mediated encounters cause reflection and perhaps action in defying the status quo. Hansen (2008) asserted the achievement of critical consciousness for an oppressed people allow identification of specific needs, embracing obstacles to problem solutions and an identification of needs within the framework of the operative function of society. Participatory democratic efforts to resolutions can be promulgated.

The goals of critical theory are transformative. Hansen (2008) purported, “The ultimate goal of critical theory is thus to transform societal relationships and institutions that are exploitative, creating a more equitable society. Power in social relationships is the central organizing concept around which critical theory is organized” (p. 407). Hansen (2008) posited, “Critical theory is relevant for the field of conflict resolution because it offers conflict resolution practitioners and scholars a framework that can guide them in assisting parties to overcome societal and interpersonal oppression and injustice” (p. 403).

It is necessary to attest to the sound underpinnings of societal distinct ways and mores of relating to those who are unjustly treated, and the structures and actions which impose those injustices. Such actions are typified when the oppressor, attempts to dehumanize the oppressed. Gil (1998) further clarified the relevancy of oppression, the social tools used and the impact on the oppressed, which provides clarity to hierarchical schemes and the implied injustice. Gil (1998) posited,

> Oppression refers to a mode of human relations involving domination and exploitation—economic, social, and psychologic—between individuals; between social groups and classes within and beyond societies; and globally, between entire societies. . . .Injustice refers to coercively established and maintained inequalities, discrimination, and dehumanizing, development-inhibiting conditions of living (e.g., slavery serfdom, and exploitative wage labor; unemployment, poverty, starvation, and homelessness; inadequate healthcare and education), imposed by dominant social groups, classes, and peoples upon dominated and exploited groups, classes, and people (Gil, 1998, p. 10).

Health care disparities and health disparities constitute unequal health care of minority groups in comparison to dominant group members. Social groups who lack power such as the victims, in the USPHS Tuskegee Study of Untreated Syphilis in the Male Negro denotes exploitation to a powerless group in a Black Belt county in rural Alabama of mostly illiterate farmers and sharecroppers who sought illusionary healthcare. According to Ho (2007),

> Racial inequality, often coupled with poverty, experienced by African-Americans is an institutionalized social structure that lowers the level of actual fulfillment of one's fundamental needs, such as healthcare, below the potential, where the potential is defined by the availability and access that other American citizens enjoy. Thus, racial inequality is an example of structural violence and inequality itself is constitutive in the definition of avoidability and potential. Inequality, *prima facie*, betrays the fact that an unrealized fundamental human need is avoidable. It also establishes a certain level of what constitutes the potential by comparing it to what others can achieve. (p. 4)

Ho (2007) further purported, "… in the case of racial inequality in America, social structures, particularly racism, systematically disadvantage African-American men and women who suffer from unequal life chances" (p. 4).

Overview of Critical Theory and Variant Critical Theoretical Ideologies

According to Polit and Beck (2004), Critical Theory originated in the 1920s from German scholars who embraced a Marxist philosophy, known collectively as the Frankfurt School. The different variations of critical theories in the social sciences provide a rich dialogue, rhetoric and various lens for application and exploration. Scholars or researchers who embrace a social theoretical perspective, maintain a conviction of concern for societal issues, perhaps for those who are disenfranchised in some demeanor; critical researchers can offer *hope* through envisioning new paradigms and new ways of empowering others, new possibilities are explored, through an action oriented approach. A goal of critical theory is to incorporate theory and practice, allowing others to view disparities and contradictions in philosophies, values and social practices; to present reflection for agency or change to occur.

At its core, CRT is committed to advocating for justice for people who find themselves occupying positions on the margins – for those who hold ‘minority’ status and the lack of power that marginality holds for victims that are powerless to make changes in structural elements that exists in the system. It directs attention to the ways in which structural arrangements inhibit and disadvantage some more than others in society. It spotlights the form and function of dispossession, disenfranchisement, and discrimination across a range of social institutions, and then seeks to give voice to those who are victimized and displaced. CRT, therefore, seeks not only to name, but to be a tool for rooting out inequality and injustice (p. 8).

Praxis is essential, transformative ideologies can occur from the researchers’ perspective and in sociopolitical contexts. “In this way, critical theory calls for *praxis,* addressing real-world problems and constraints, rather than armchair theorizing” (Hansen, 2008, p. 207). Hansen (2008) further implied the philosophical dynamics relative to reflection and action, which informed,

> *Praxis* is the reciprocal, dynamic, and reflexive relationship that practitioners engage in when their theorizing about societal oppression informs their actions taken to challenge that oppression, and vice versa. *Praxis* also puts the scholar or practitioner in a position of continuous reflection, questioning the theory-action relationship in order to continuously revise his or her approach. A *praxis* orientation is inherently future-oriented and hopeful, with scholar practitioners creating new visions for societal

> relationships in overcoming societal domination, which in turn are an impetus for further societal analysis and action. (p. 409)

For the context of focus for this study it is necessary to clarify peace research, structural violence and its significance to critical theory methodologies. To provide clarity, Patomäki (2001) asserted,

> The challenge of critical theories to peace research is twofold. On the one hand, critical theories spur the development of an emancipatory ontology and methodology. On the other, they force us to take seriously the politics of identity and the conditions for practical political activity inherent within peace research. It is the task of peace research to show how existing historical trends and tendencies can be overturned. Peace research as to act consistently to prevent a transformation from politics to violence and to promote, instead, a transformation towards peaceful, democratic world politics. (p. 734)

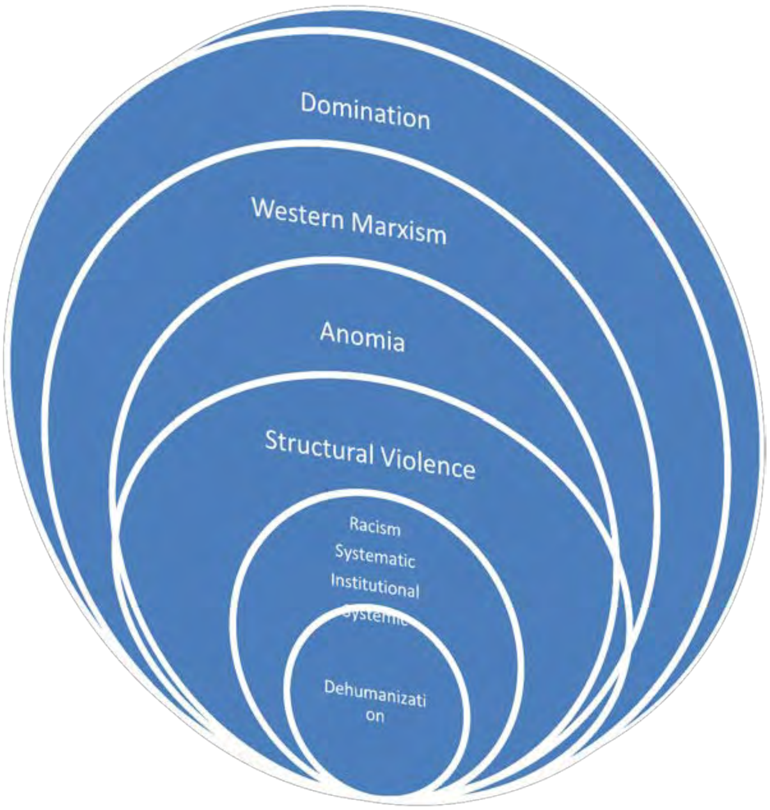


Figure 3. Lett's Social Structure Critical Theory Construct Model

Injustice, Inequity, Health Care Disparities and the Use of a Critical Theory Framework

Ford and Airhihenhuwa (2010) developed a framework for understanding health disparities from an epidemiological perspective, adding to the social context of the discussion of inequity in health care. Ford and Airhihenhuwa (2010) posited,

> A primary objective of critical theory is to evaluate and advocate for justice and fairness in society. This kind of evaluation seeks a balance between the descriptive methods typified in the utopian reach of socio-political philosophy and the explanatory methods typified in some of the uncritical premises of the social sciences. (p. 1395)

The USPHS Study of Untreated Syphilis in the Negro Male is an exemplar of structural violence. Scholarly literature denotes rhetoric and paradigms of a continued existence of systematic, systemic and institutional violence to a race of people who are disenfranchised in so many instances, impacting all facets of social life, altering trust, quality of life; compromising hope.

Feldman (2006) stated,

> Surveying the South in1944 Gunnar Myrdal concurred: The issue of white supremacy vs. Negro domination as it is called in the South, has for more than a hundred years stifled freedom of thought and speech and affected all other civic rights and liberties of both Negroes and whites in the South. It has retarded its economic, social and cultural advance. On this point there is virtual agreement among all competent observers. (p. 368)

Washington (2009) conveyed, the relationship between the vestiges of enslavement, race, and the social constructions of race, and their impact on the quality of healthcare of diverse populations, particularly for African Americans is well documented (p. 966).

The USPHS Study of Untreated Syphilis in the Negro Male commencing in 1932 compromised the global health status of a powerless subpopulation in Macon County. A group of men with a multigenerational status of slavery, lacking all forms of social goods, were disvalued by dominant group members. Untreated syphilis in latent stages not only shortened life spans, but unnecessarily brought the advent of untreated disease to family members and unborn children.

Truman et al. (2011) clarified differences in terminology and verbiage of like terms when referencing differences in health status among social groups. Health disparities, health inequalities and health inequities, can be confusing and used inappropriately when discussing problems of underutilization of the health care system by minorities and how the lack of use impacts quality of life. Truman et al. (2011) makes the following distinctions relative to terminology,

> *Health disparities* are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes. *Health inequalities,* which is sometimes used interchangeably with the term health disparities, is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity). *Health inequities* are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair. Health disparities, inequalities, and inequities are important indicators of community health and provide information for decision making and intervention implementation to reduce preventable morbidity and mortality. (p. 3)

The USPHS Study of Untreated Syphilis in the Negro Male in a Historical Context

Scholarly discourse leads to an objective analysis of any enigmatic aberration. It is necessary to scrutinize and thrash out the customs, mores, the racial climate, the significance of the epoch and power structure of social groups of a given time period. Black Americans, according to Earl (2011), were often portrayed as the poster child for immorality and disease alterations, despised by many majority members with the connation of seemly born with a curse; post the flood, given the flawed biblical recantation of Noah cursing his son. Black skin was conceptualized as an alteration to the norm, with the paradigmatic belief that Negroes were "othered", given the status of inferiority to the superiority-imbibed position of European

Americans. Efforts to dehumanize Black Americans began with their enslaved presence on the slave ship, and transcends to the 21st century. Brandt (1977) postulated,

> A brief review of the prevailing scientific thought regarding race and heredity in the early twentieth century is fundamental for an understanding of the Tuskegee Study. By the turn of the century, Social Darwinism had provided a new rationale for American racism. Essentially primitive peoples, it was argued, could not be assimilated into a complex, white civilization. Scientists speculated that in the struggle for survival the Negro in America was doomed. Particularly prone to disease, vice, and crime, black Americans could not be helped by education or philanthropy. Social Darwinists analyzed census data to predict the virtual extinction of the Negro in the twentieth century, for they believed the Negro race in America was in the throes of a degenerative evolutionary process. (p. 21)

Theory of Inferiority

Inferiority theories abound even with the paradigm that blacks were not intellectually sound but were subhuman and sexually altered anatomically compared to the dominant social group. Myrdal (1944) posited,

> If white Americans can believe that Negro Americans belong to a lower biological species than they themselves, this provides a motivation for their doctrine that the white race should be kept pure and that amalgamation should, by all means, be prevented. The theory of the inborn inferiority of the Negro people is, accordingly, used as an argument for the antiamalgamation doctrine. This doctrine, in its turn, has, as we have seen, a central position in the American system of color caste. The belief in biological

> inferiority is thus another basic support, in addition to the no-social-equality, anti-amalgamation doctrine, of the system of segregation and discrimination. (p. 102)

It is important to discuss the time span of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male commencing in 1932. Gunnar Mydral's study on race relations was conducted in 1944. Most scholars on race relations contend that conceptualization of racial inferiority theories continue to transcend centuries and generations. Wright and Rogers substantiate these findings. According to Wright and Rogers (2010),

> The attribution of intellectual inferiority meant that blacks were seen as lacking intellectual capacities for rational action, and thus, as in the case of children, choices should be made on their behalf by responsible adults. The attribution of moral inferiority supported the view of blacks as inherently dangerous, ruled by passions, both aggressive and sexual, and thus incapable of exercising liberty. These beliefs constituted the core of the racist culture forged under slavery and although such beliefs were increasingly challenged in the last decades of the twentieth century and are no longer seen as respectable, they continue to influence race relations to the present. (p. 7)

Brandt (1977), postulated, the alteration and significance was abound as Black Americans were "othered" in inhumane contexts. Brandt (1977) conveyed,

> Interest in racial differences centered on the sexual nature of blacks. The Negro, doctors explained, possessed an excessive sexual desire, which threatened the very foundations of white society. As one physician noted in the Journal of the American Medical Association, 'The negro springs from a southern race, and as such his sexual appetite is strong; all of his environment stimulate this appetite, and as a general rule his emotional type of religion certainly does not decrease it.' (p. 21)

Mydral (1944) postulated regarding the nuances relative to sexual rhetoric occurring during the time era.

> The belief that Negro males have extraordinarily large genitalia is to be taken as an expression of a similar sexual envy and, at the same time, as part of the social control devices to aid in preventing intercourse between Negro males and white females. (p. 108)

This paradigm of supremacy theory through varied context is affirmed through scholarly acumen viewed by Jones (1993) who confirmed,

> They perpetuated the ancient myth that blacks matured physically at early ages and were more sexually active throughout their lives than whites. Blacks, they explained, had originated in a warm, tropical climate and were therefore closer on the evolutionary scale to man's bestial ancestors. Physicians pointed also to alleged anatomical and neurological differences. The formidable penis of the black man with its long prepuce offered greater opportunity for infection. Moreover, personal restraints on self-indulgence did not exist, physicians insisted, because the smaller brain of the Negro had failed to develop a center for inhibiting sexual behavior. (p. 23)

No doubt, a profound belief of the Black man's desire for White women factored into ill regard and fed into the need for dehumanization. Brandt (1977) conveyed,

> A particularly ominous feature of this overzealous sexuality, doctors argued, was the black males' desire for white women. 'A perversion from which most races are exempt,' wrote Dr. English, 'prompts the negro's inclination towards white women, whereas other races incline towards females of their own.' Though English estimated the 'gray matter of the negro brain' to be at least a thousand years behind that of the

white races, his genital organs were overdeveloped. As Dr. William Lee Howard noted:

> The attacks on defenseless white women are evidences of racial instincts that are about as amenable to ethical culture as is the inherent odor of the race.... When education will reduce the size of the negro's penis as well as bring about the sensitiveness of the terminal fibers which exist in the Caucasian, then will it also be able to prevent the African's birth-right to sexual madness and excess. (pp. 21–22)

Physical Violence and the Negro

Given the historical specificity of the time era, lynching and the terror from the KKK was a prevalent occurrence. Wright and Rogers (2010) conveyed,

> The Ku Klux Klan was tacitly supported by the state and allowed to terrorize black communities. Lynchings were the most extreme form of such violence and were a common event in parts of the South from the 1880s through the first decades of the 20th century…. But violence against blacks was not simply tolerated by state authorities in the South; it was also official state policy. This is revealed starkly in the statistics on executions for rape by race in the period before the 1960s.… From 1930–1960 between five and 25 black men were executed annually for rape in the United States, nearly all in the South, whereas for whites the numbers were never more than 4 and in most years zero or 1. (p. 9)

Brandt (1977), substantiated a medical view of "castration instead of lynching", and implied,

> One southern medical journal proposed 'Castration Instead of Lynching,' as retribution for black sexual crimes. 'An impressive trial by a ghost-like kuklux klan [sic] and a

> 'ghost' physician or surgeon to perform the operation would make it an event the 'patient' would never forget,' noted the editorial. (p. 22)

Paris (2012) portrayed and situated the historical features of the epoch, providing a clear analysis of the customs and mores of the time era in which the USPHS Study of Untreated Syphilis began in 1932. Paris (2012), in situating a background of the specificity from a historical perspective, espoused,

> …the USPHS Study of Untreated Syphilis on the Male Negro … began in 1932 and for many decades both before and after, the state of Alabama and all other states in the south were racially segregated in all dimensions of social life. The Civil Rights Act of 1964 and the Voters Rights Act of 1965 were more than three decades in the future. It would be a half century later before so-called Negroes would freely adopt the name "African American" as their preferred self-identity: a name that designated the continent of their origin rather than their racial designation. (p. 10)

The oppressiveness and rendered domination to Negroes in 1932, was vast, consistent, and uniform; an everyday occurrence. The significance of domination and oppression from a philosophic paradigm to lower ranking people of color denotes superior difference from the higher ranking social group of which some scholars signify as maintaining the caste system. The given history of chattel slavery and the lack of power systematically in the South and America was ingrained and incomprehensible, an unequal power structure was recognized as law. Paris (2012) posited, "At that time every black person in Macon County was subservient to whites. Those who were not risked abuse or even the loss of their lives" (p.11). During this epoch, systemic, personally mediated, systematic and institutional racism was the custom and law. Paris (2012) proclaimed,

> Suffice it to say that in 1932 all descendents of enslaved Africans in the south and large parts of the north were oppressed in every conceivable way by the white population. In fact, two unequal societies lived side by side; the one black and powerless, the other white and tyrannical. Various legal and social structures sustained the inequality and disrespect for blacks even when the latter comprised the majority. Those structures were designed and enforced by law, re-enforced by official violence and the threat of the same for the most minor offenses. In addition, the informal vigilantism of the Ku Klux Klan [KKK] regularly terrorized the so-called Negro communities by their clandestine practices of burning properties and lynching men. In short, the lives of so-called Negroes were very cheap and totally unprotected by the law. (p. 11)

When reviewing the customs, laws, historical vestiges and the framework of the structural barriers and the hegemony associated with living in Alabama's Black Belt South in 1932, Paris (2012) conveyed,

> Alabama's infamous so-called Scottsboro Boys Case occurred in 1931 as one of the greatest miscarriages of justice in United States legal history. It was preceded by the Plesy v Ferguson case in 1896 when the United States Supreme Court established the separate but equal law of racial segregation which remained the law of the land until it was overturned in the 1954 *Brown v the Board of Education* decision. (p. 11)

Race relations in the Deep South in 1932 contended with a macrocosm of race relations in America, particularly for the Northern states, and a lack of social acceptance in all realms of life for a Negro people. Albeit some group factions of racial hatred were specific to location and rurality, time and space. According to Feldman (2006), "White southerners saw

> themselves as part of a section of the country that, in effect, was its own country with its own culture, its own customs, and – like other nation-states – with its own sovereignty, …" (p. 366)

Dollard (1932) posited, "White aggression against Negroes and the social patterns which permit it are forms of keeping the Negro in his place and maintaining the subordinate position of the white caste" (p. 315). Dollard (1932) supported assumptions from his findings relative to social mores, patterns of behavior, and stratification of the power structure between European Americans and Negroes. In analyzing the social conduct and agency, extending from the members of the dominant race, Dollard (1932) surmised,

> We now know from our study that the whites do not fight for social superiority just for fun; on the contrary, they are attempting to minimize or eliminate Negro competition in the spheres of economics, sex, and prestige. Competition when it does appear, in the form of aggressive demands or acts on the part of the Negro which are directed toward the modification of the superior advantages enjoyed by the white caste. (p. 316)

Satcher (2011) elucidated further the essence of the social conditions and constraints of the time era. Satcher (2011) conveyed,

> …during most of the Tuskegee Study, the social conditions that were dominant were those that characterized much of the American history of race relations. Poverty, social exclusion, ignorance, and little or no access to healthcare describe the plight of African Americans in Tuskegee and much of America, but especially in the South and especially in Alabama. Discrimination in education, employment, income, access to health care, and violence and threats of violence prevailed in the plight of the Negro in the South and again especially in Alabama…. (p. 45)

It should be noted also that the major designer, advisor and publisher for the USPHS Study of Untreated Syphilis in the Male Negro was Dr. Joseph Earle Moore, Head of Johns Hopkins University Medical School from 1929–1954 who believed all of his life that the disease of syphilis in Negroes was different from that in whites. According to Jones (1993), "A rare point of agreement among the competing factions was that the health of blacks had to be considered separately from the health of whites" (p. 16). Historically, physicians did a lot to "bolster" the racial attitudes of difference between the two races (Jones, 1993). Jones (1993) conveyed, "Physicians did not dissent as a group from white society's pervasive belief in the physical and mental inferiority of blacks" (p. 16). Byrd and Clayton (2000) posited, "These unwholesome trends and ideologies buttressed and fed into the concomitant 200-year old U.S. biomedical tradition of unethically exploiting and over utilizing Blacks and the poor for experimental, demonstration, and research purposes" (p. 412). Byrd and Clayton (2000) confirmed negative differential treatment of Black Americans to the 21st century authenticating, "Legacies of this tradition, often in different guises, linger today" (p. 412).

It is interesting to consider the paradigms that influenced the ideologies of the Syphilis Study, with Southern evangelical European Americans assuming the intrinsic belief that emancipation had a negative and detrimental effect on Negroes. Byrd and Clayton (2011) further situated the racial milieu and the demeanor of historicity during the time era for Black Americans. Byrd and Clayton (2011) posited,

> The atmosphere created by racial inferiority theories and stereotypes, 246 years of black chattel slavery, along with biased educational processes, almost inevitably led to medical and scientific abuse, unethical experimentation, and overutilization of African-Americans as subjects for teaching and training purposes. (p. 11s)

Ultimately the conceptualization of the USPHS of Untreated Syphilis in the Negro Male was far removed from an ethical approach. According to Brandt (1977),

> In retrospect the Tuskegee Study revealed more about the pathology of racism than it did about the pathology of syphilis; more about the nature of scientific inquiry than the nature of the disease process. The injustice committed by the experiment went well beyond the facts outlined in the press and the HEW Final Report. The degree of deception and damages have been seriously underestimated. As this history of the study suggests, the notion that science is a value-free discipline must be rejected. The need for greater vigilance in assessing the specific ways in which social values and attitudes affect professional behavior is clearly indicated. (p. 27)

Thus, Negroes in the 1930s when the sentinel event occurred in Macon County, to the mostly illiterate male Negro tenant farmers were not equal in social status and lacked social goods, were rooted in a history of chattel slavery and varied endemic structural mechanisms. The study was designed and orchestrated with the provision of not providing treatment to the vulnerable Negro males. Coming from the supremacist perspective, the pseudoscience experiment was one of inequity –leading to the false assumption and exploration of the detrimental pathophysiological effects of syphilis in the Negro male.

Structural Violence

Johan Galtung (1969) conceptualized a theory of structural violence, additionally constructed as “peace research”. Ho, (2007) posited,

> Structural violence theory aspires therefore to provide a nuanced structuralist analysis of the relationship between structures and agency. These structures result in an unequal distribution of resources which results in actively constraining agency. For structural

> violence theorists, the distribution of power through structures, whether it is called exploitation or violence, enhances the agency of some but at the expense of constraining the agency of others. (p. 5)

Galtung (1969) extensively explores various dimensions of violence, six in totality. The six dimensions assume an understanding that “violence is present when human beings are being influenced so that their actual somatic and mental realizations are below their potential (p. 168). The dimensions of violence discussed by Galtung (1969) are all plausible and provide sound and viable discourse. However, the theoretical framework of this study will be prefaced with the fourth distinction, structural violence, which typifies whether or not there is a subject (person) who acts. A piece on cultural violence written by Galtung in 1990 also provides useful discourse for discussion and is applicable, particularly so, to cultural groups of color. Galtung indicated relative to the, “fourth distinction to be made and the most important one is on the subject side: “whether or not there is a subject (person) who acts” (p.170). Galtung characterizes this type of violence as structural violence.

Galtung (1969) illustrated various types of violence as typologies of violence are contextualized. Violence portrayed by various actors in some contexts and no overt visibility of actors in other contextual arenas impacts those in most instances who are vulnerable, disenfranchised or bounded by some imposed barrier of life circumstance whether perceived physical, biolognistic or social construction of differences. Individuals impacted by seamless violent acts which are structural, often encounter disparities which are enduring and destructive. Farmer et al. (2006) postulated,

> The term ‘structural violence’ is one way of describing social arrangements that put individuals and populations in harm’s way. The arrangements are structural because

> they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities). (p. 1686)

The brutality of violence of this type is significant to the totality of one's being. Galtung (1990) stated, "A violent structure leaves marks not only on the human body but also on the mind and spirit" (p. 294). Galtung (1990) makes the valid assumption that "peace" is the absence of violence and attempts to attain "peace" impacts social goals or orders. According to Ho (2007),

> Structural violence theorists define violence as the avoidable disparity between the potential ability to fulfill basic needs and their actual fulfillment. The theory further locates the unequal share of power to decide over the distribution of resources as the pivotal causal factor of these avoidable structural inequalities (p.1).

The theory of structural violence substantiates an inequitable power base in determining resource distribution which is the pivotal causal factor of avoidable structural inequalities. Ho (2007) corroborated, "…structural causes are responsible for constrained agency…. It is the effect of structures on individual agency that results in this gap between potential and actual fulfillment of rights" (p. 1). Ho (2007) purported, "when agency is constrained to the extent that fundamental human needs cannot be attained, structural violence becomes a structural violation of human rights" (p. 1). Special protection for social and economic rights have been marginalized under the broader spectrum of civil and political rights (Ho, 2007).

In an analysis of socio-political structural issues in the Deep South, Hattery and Smith (2007) contended,

> No examination of contemporary race or class relations can be understood without understanding this particular socio-political economy of the American South, a region that has always been characterized as a class-divided society with great distinctions between rich and poor. (p. 58)

Ho (2007) conveyed, "structural violations are paired with images of a different nature: starving children, diseased bodies, and desperate poverty. The complex nuance of structural violence is specific to social, economic and political factors" (p. 10). In the Deep South, there exists a precedence to explicate structural issues of violence in light of the premise of their existence. Hattery and Smith (2007) posited,

> Turning to an examination of the Deep South (Alabama and Mississippi) we see that citizens here are almost twice as likely to live below the poverty line than the general US population. In Alabama, 12.5% of households and fully 16% of Mississippi households (nearly twice the national average) are below the poverty line, as compared with only 9.2% of total households in the rest of United States. (p. 59)

Violent acts impact the psyche. Galtung (1990) expressed the seriousness and gravity of violent acts upon the holistic nature of a human being. Galtung (1990) purported,

> Violence is needs-deprivation; needs-deprivation is *serious*; one reaction is direct violence. But that is not the only reaction. There could also be a feeling of [**hopelessness**]**,** a deprivation/frustration syndrome that shows up on the inside as self-directed aggression and on the outside as apathy and withdrawal. (p. 295)

When discussing frameworks of violence encompassing peace and conflict theory, Galtung (1990) conveyed, "violence studies are about two problems: the use of violence and the legitimation of that use" (p.291). Galtung's theory of structural violence encompasses the circumstances of violence specifying, “violence is present when human beings are being influenced so that their actual somatic and mental realizations are below their potential realizations” (p.168). The actual could be great if realized, however, the detriment is that the potential never becomes actualized because of negative and ill assumed barriers which are structural in nature. Galtung (1965) conveyed,

> “the potential level of realization is that which is possible with a given level of insight and resources. If insight and/or resources are monopolized by a group or class or are *used for other purposes*, then the actual level falls below the potential” (p. 171).

Galtung voiced, “When the actual is unavoidable, then violence is not present even if the actual is a very low level” (p. 171).

In order to further define and clarify, Galtung (1969) surmised, “violence is here defined as the cause of the difference between the potential and the actual, between what could have been and what is” (p.168). Violence is that which increases the distance between the potential and actual, and that which impedes the decrease of this distance (p.168). So, when the potential is higher than the actual the difference is by definition avoidable and when it is avoidable, then violence is present (Galtung, 1969).

To further elucidate and apply Galtung’s (1969), theory of structural violence, in a healthcare domain, an illustration is made to acquiring tuberculosis. If a person died today from drug resistant tuberculosis, perhaps a structure is in place to prevent that individual from procuring treatment modalities to prevent a further decline in health or death. In comparison, one hundred years ago this resulting decline in health from a lack of treatment for tuberculosis could not evoke a structural component or barrier, even more specifically if the individual was a Northern European American, death in essence, given a dominant hierarchal-perspective would result from a lack of available treatment measures. However, if the individual is a Black American, death could result from systemic, systematic, and institutional structures and/or a lack of available treatment measures as is often the case with injustices associated with inequitable health care. Barr (2008) commented on infectious diseases that ravaged Europe and North America during much of the 20th century. Barr acknowledged, "For more than a century, where you are on the social hierarchy has been a strong predictor of whether you live or die from a disease such as TB" (p. 8). Barr (2008) stated, ones' standard of living and position in the social hierarchy in fact, served as a powerful predictor of who would live or die from diseases which primarily ravaged citizenry in the 20th century in Europe and North America inclusive of TB, measles, pneumonia, diphtheria, typhoid and polio. Interestingly today, deaths most often occur from major chronic health conditions inclusive of; heart disease, stroke, complications of diabetes, cancer and other disease alterations. The Whitehall study conducted in England for 10 years, revealed an inverse relationship between employment grade and mortality. According to Marmot (1984),

> In the Whitehall study, 17,530 civil servants were classified according to employment grade, and their mortality was recorded over 10 years. There was a steep inverse relation between grade and mortality. Compared with the highest grade (administrators), men in the lowest grade had 3 times the mortality rate from coronary heart disease, from a range of other causes, and from all causes combined. This is larger than the mortality differences, nationally, between classes I and V. Smoking and other coronary risk factors are more common in the lowest grades, but these differences account for only part of the mortality difference. The similarity of the risk gradient from a range of specific diseases could indicate the operation of factors affecting

> general susceptibility. The inverse relation between height and mortality suggests that factors operating from early life may influence adult death rates. (p. 1003)

Byrd and Clayton (2000) clearly relate to structural issues, encompassing structural, social and environmental issues in the American health care delivery system. Byrd and Clayton postulated (2000),

> The reality is that poor African American health status and outcomes are not aberrations—they are pervasive and system wide. They are reflections not only of the poor performance of the health system but also of poor nutrition, being forced to live in toxin-exposed environments, poor housing, poor health habits, and health-risky behaviors. Blacks are suffering excess disease-related morbidity and mortality from chronic diseases like heart disease, hypertension, strokes, and diabetes, childhood and infant mortality rates as high as those in many developing countries. While at least 10 to 15 percent of this poor health outcome can be directly related to poor performance of the health care delivery system, some 80 percent of the excess mortality stems from treatable and chronic health conditions or preventable disease processes, which directly reflects the poor performance of the health care delivery system, as evidenced by a lack of immunizations, inability to purchase medications or to keep medical appointments, and/or physician refusal to see patients because of their poverty or insurance status. (p. 17)

Environmental injustice cannot be ignored or addressed in an isolative context when addressing structural violence intersecting with health inequities and poor health outcomes, which intersect with social determinants of health. Inadequate environmental health also contributes to health inequities. Warren (2011) posited,

> The U.S. Environment Protection Agency has ample evidence on the adverse affects of toxic and hazardous waste on human health. A 1987 report, updated in 1994, published by the Commission for Racial Justice of the United Church of Christ found that communities where racial minority populations lived had significantly more commercial hazardous-waste facilities than communities consisting of non-Hispanic whites regardless of income status. (p. 147)

Structural determinants are pervasive in altering positive health outcomes. A historical example is the plight of the victims of Hurricane Katrina, which caused intense damage in varied environmental and physiological contexts in New Orleans, Louisiana (LA). An analysis of the aftermath associated with Hurricane Katrina yielded in-depth structural issues; thus, Black Americans experienced insurmountable violence as a result of historical and entrenched systematic, systemic and institutional racism. Media coverage portrayed varied images of inhumane conditions. Individuals existed and suffered for days without basic liberties inclusive of food, healthcare, clothing, shelter, and other basic necessities assumed and associated with living in a democratic society. The alteration of space and place, in comparison to dominant group members was inequitable. Hattery and Smith (2007) observed the exposed profound structural violence experienced by New Orleans, mostly Black American residents during the devastation inflicted by Hurricane Katrina. Hattery and Smith (2007) conveyed,

> Equally troubling was the new reality that many New Orleans residents were living in impoverished conditions and almost total racial segregation. New Orleans was 67% African American with virtually no contact between the races. Many neighborhoods were 90 to 100% black, and, fewer than 20% of all these residents' interactions are with whites. (p. 75)

Louisiana falls within the category of being a Black Belt state with many notable features in New Orleans encompassing and resembling characteristics of the Jim Crowism landscape of the Black Belt of Alabama, ingrained, persistent and well-established, segregation remains entrenched which influence social determinants of health on a broad scale. Rhetoric would surmise that Black Americans in New Orleans relegated a status of second class citizenship.

Wright and Rogers (2010) surmised,

> Second class citizenship refers to a situation in which some categories of citizens have fewer rights than others. This can either take the form of an official, legally defined denial of some rights, or a less formal practical denial of rights. Laws which prohibit people who have been convicted of felonies from voting, … are an example of legally-defined second-class citizenship that is still common in the United States today. Police practices which target certain groups of people for stricter law enforcement or judicial practices which systematically impose stiffer sentences on particular categories of people would be examples of unofficial second class citizenship. Public policies which treat some categories of citizens as more worthy of respect than others can also be seen as creating a kind of second class citizenship … the public disrespect of poor African-Americans reflected in the abandonment of the people left behind in New Orleans during the Hurricane Katrina disaster in 2005 is a striking example of their denial of full recognition as equal citizens. Official second-class citizenship became the pivotal form of racial oppression in the United States, especially in the South, in the decades following the Civil War. (p. 8)

Hattery and Smith (2007) had confirmed the status of the segregated and racially entrenched landscape of residents in New Orleans prior to the analysis by Wright and Rogers. Hattery and Smith (2007) confirmed,

> The South, the nation's most "diverse" region, remains as highly segregated today as it was 50 or 150, or even 350 years ago. Among the important concepts that Hurricane Katrina exposed was the high level of both social segregation and racial segregation in the United States as a whole and in the South in particular. The images were powerful, in part because New Orleans is a large city contained in a small area. (pp. 75–76)

Racism, though not a popular concept for dialogue, the historical legacy continues in the broader landscape of American society impacting for disadvantaged groups. The accumulated social disadvantage of Black Americans remains insidious in the fabric of American society. The impact of Hurricane Katrina exposed the crevices of racism making the long terms effects public for the world to view. Airhihenbuwa and Liburd (2006), conveyed,

> …[in]response to public outcries about the slow moving evacuation of victims of Hurricane Katrina, President Bush acknowledged during a news conference that a history of racism is responsible for the present condition of poverty in which a disproportionate number of Black Americans find themselves. Such a history of being consigned to conditions of poverty results in what Wilson (1978) referred to as "accumulation of disadvantage." (p. 489)

Measures of social injustice were conducive to living in the Ninth Ward in New Orleans, with an absence of egalitarianism. Thus, the issue of environmental justice is affront in neighborhoods for a marginal and disenfranchised people. For example, certain people in New

Orleans post-Katrina still are living in spaces that were defanged extensively by the flood and determined to be environmentally unsafe.

In addition, a Report of the National Advisory Commission on Civil Disorders (1968) done by the Kerner Commission found,

> Segregation and poverty have created in the racial ghetto a destructive environment totally unknown to most white Americans. What White Americans have never fully understood—but what the Negro can never forget—is that white society is deeply implicated in the ghetto. White institutions created it, white institutions maintain it and white society condones it. (Para I).

In comparison, according to the Kirwan Institute (2012), a home in the suburbs is typically associated with good, high-performing schools; high-performing schools are associated with increased access to college; increased access to higher education is associated with the ability to buy a home in the suburbs. So, over time, opportunities accumulate for an individual because of where they live. In light of the demographics of American suburbs, the person in this scenario is most likely White (p. 3). However, when the scenario is reversed for low-power social hierarchical members,

> … living in a highly segregated and isolated inner-city neighborhood is associated with poor-performing schools; poor performing schools are associated with high drop-out rates; high drop-out rates are associated with low-paying jobs; and low-paying jobs are associated with living in segregated inner-city neighborhoods. These disadvantages accumulate over time. In light of the demographics of racial segregation in U.S. metropolitan areas, the people impacted by this story are most likely Black or Latino. (Kirwan Institute, 2012, p. 3)

The type of violence which involves an actor is classified as direct or personal violence and of violence where there is no actor involved as structural violence or indirect violence. For clarification, with structural or indirect violence actors might not be involved, but “the violence is built into the structure and shows up as unequal power and consequently as unequal life chances” (p. 171). The resultant inequalities and unequal life chances allow for an inequitable distribution of resources reflected by income distributions, literacy and education, medical services, etc. Often individuals who are disenfranchised experience inequalities associated with low socioeconomic status, inferior education and biased health care, thus resulting in a form of structural violence. In essence, the institutionalization of poverty impacts many venues in education, healthcare, where one resides, etc.; thereby structures are eminent and pervasive. Galtung (1969) further expounded,

> Resources are unevenly distributed, as when income distributions are heavily skewed, literacy/education unevenly distributed, medical services existent in some districts for some groups only, and so on. Above all, *the power to decide over the distribution of resources* is also low on education, low on health, and low on power—as is frequently the case because of social structure. (p. 171)

Hattery and Smith (2007) makes a distinct analysis of poverty and social location referencing the segregable and isolative living arrangements of Black and European Americans of which Galtung’s conceptualization of structural violence revealed. Hattery and Smith (2007) conveyed, “African Americans and whites live in isolation from one another, and just as in New Orleans, African Americans live in the areas where poverty is more extreme, making successful life chances less probable” (p. 76). Restriction of resources according to Hattery and Smith (2007) impacts,

> …poverty, access to education, the opportunity to own a home that accumulates value, and the likelihood that a child will survive its first year of life vary by county across Alabama and Mississippi, and that this variance is clearly *structured* by racial and social segregation. The more residents of African American descent who live in a particular county, the lower the standard of living, the higher the rate of poverty, and the less access to the opportunity structure. This narrow opportunity structure perpetuates the poverty, sub-standard housing, and educational deficits. (p. 76)

Waterhouse (2009) conveyed the mindset of Dr. Martin Luther King toward the end of the Civil Rights Movement, of expressing frustration with the obstinate de facto segregation in Northern cities, impacting millions of Black Americans implying that the success of the first decade of the movement was misleading relative to the depth of the suppression of anger by Blacks in the north and "the amount of bigotry" which was disguised by America's White majority. Dr. King stated, "…the white power structure is still seeking to keep the walls of segregation and inequality substantially intact…" (p. 170).

According to Galtung (1969), 'individuals may be killed or mutilated, hit or hurt. In personal or direct violence, "consequences can be traced back to concrete persons as actors; in the second case this is no longer meaningful. There might not be a person who directly harms another person in the structure. However, where structural violence subsists, perpetrators or actors might not be visible; often a cancelable voice is present. Historically, for Black Americans, an endurance of personal violence cannot be negated. The KKK mobs tortured and lynched Black Americans in greater numbers prior to 1932, albeit, there are modern day accounts of lynching of Black Americans. Beck and Tolnay (1990) purported, "For our purposes, a lynching is defined as the killing of one or more blacks at the hands of an extra-legal mob of three or more individuals" (p. 530). According to Beck and Tolnay (1990), "Between Emancipation and the Great Depression, about 3,000 blacks were lynched in the American south" (p. 526). The theoretical bases of the projection of the manifestation of actual lynching conducive to malevolence are varied but inclusive of: (a) political threats, (b) economic competition, and (c) the caste boundary (Beck & Tolnay, 1990). "Given the Deep South's racial caste structure, whites could harass and assault blacks with virtual impunity. Blacks were considered legitimate, and even deserving, objects for white wrath (Beck & Tolnay, 1990, p. 537). The epochal difference of "maintenance of the *caste boundary* … assured whites superior social status, despite the often minuscule difference between the economic well-being of blacks and whites" (p. 528). The unequal power structure has pervaded centuries and continues to transcend to the 21st century. Quotidian prejudices are customary and routine, transcending through routine "microaggressions" to people of color, and those so "othered". Some scholars contend that microaggressions occur more so to Black Americans due to the structural features of racism. According to Sue et al. (2007), "Microaggressions are the brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, deroga-tory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group" (p. 271). Implicit associations of bias and stereotypical thoughts relative to race can be imbedded in ones subconscious thoughts, as confirmed by *Project Implicit* studies from Harvard University (Hardin and Banaji, 2010).

Violence and the Market Place

Galtung (1969) indicated above all, "the power to decide over the distributions of resources is unevenly distributed" (p.171). The problem is further confounded when such inequalities are pervasive which often is the case given the social structure. From a Marxist perspective or criticism of a capitalist society, the decision on how the market place is managed is decided by those with power. Galtung (1969) postulated:

> How the power to decide over the surplus from the production process is reserved for the owners of the means of production, who then can buy themselves into positions on all other rank dimensions because money is highly convertible in a capitalist society–if you have money to convert that is. Liberal criticism of society similarly emphasizes how power to decide is monopolized by small group of convert power in one field into power in another field simply because the opposition cannot reach the stage of effective articulation. (p. 171)

Marxist theoretical constructs encompass class and the market place restricting the members of the proletariat to meager earnings with no way to ascend the social tier of which the bourgeois assume in capitalistic society. In essence, "Marx viewed social classes as groupings of individuals who played similar roles in the economic system…" (LaVeist, 2005, p.158). LaVeist (2005) postulated socioeconomics "is a system of stratification whereby individuals are classified along various dimensions of social class" (p.158). Thus, "exploitation of the lower class" is an integral part of capitalism. However, according to Marx, "the level of societal resources", which one is able to access, comes from either their exploitation or a disproportionate amount of acquired goods and benefits from the capitalist system (LaVeist, 2005, p.158). The labor of the proletariats in essence, benefitted the bourgeoisie. Class conflict according to Marx was inevitable (LaVeist 2005). An explanation by some scholars denotes exploitation as an approach of stigmatizing a particular group as inferior, thus, justifying subordination. According to Bonilla-Silva (1997) "…orthodox Marxists (Cox, 1948;

Perlo, 1975; Szymanski, 1981, 1983), who regard class and class struggle as the central explanatory variables of social life, reduce racism to a legitimating ideology used by the bourgeoisie to divide the working class" (p. 466).

According to Tong (1998), "under capitalism, Marx suggested, people are largely free to do what they want to do within the confines of the system, but they have little say in determining those confines, which make them behave like self-interested egotists" (p.101). "Personality … is conditioned and determined by quite definite class relationships" (Marx & Engels, p.199).

Weber, viewed by some as a neo-Marxist, saw the social system as having varied societal dimensions, thus influencing placement in the hierarchical structure. According to LaVeist, (2005)Weber connoted, "a person's opportunities in life as resulting from multiple stratification dimensions… inclusive of but not limited to, religious affiliation, education, occupation or birthrights and privilege from a 'noble family'" (p. 159). Marx and Weber were both in agreement that societal dimensions and structures dictated placement "within social stratification hierarchies" (LaVeist, p.159). Varied measures are conducive to indicators of one's socioeconomic status. A composite picture is formed from the determined indicators, which influence the position with the social stratification system. Typically, the indicators used are inclusive of: (a) education, (b) poverty, (c) income, (d) occupational prestige, (e) wealth, and (f) a combination of indexes which combine occupational prestige, income and education (LaVeist, 2005, p. 159). The influence of socioeconomics on health is powerful. LaVeist (2005) posited, "As socioeconomics increase, health status improves in a linear fashion" (p. 170). LaVeist (2005) characterized this construct as the social gradient theory. "The type of relationship is also called a dose-response relationship; the higher the "dose" of socioeconomics, the better health outcomes" (LaVeist 2005, p. 170). The social gradient theory or dose-response relationship is distinguished by the linear relationship of socioeconomics and health (LaVeist, 2005).

Other theories which influence health outcomes are essential for exploration and include (a) "social mobility", (b) "social causation and social drift", (c) "social context and income inequality" (LaVeist, 2005, p. 178). The social selection theory posited that individuals with less health status cannot accrue human capital which impacts a presence in the educational system, thereby attaining specialized knowledge to compete in the global market place. LaVeist (2005) clarified, "although there are substantial differences in socioeconomic status by race/ethnicity, it is not the case that racial/ethnic differences in health status are merely the results of differences in socioeconomic status" (p.178).

Galtung (1969) conveyed, "If insight and/or resources are monopolized by a group or class or are used for other purposes, then the actual level falls below the potential level, and violence is present in the system" (p. 169). Specific structural barriers are specific to the fundamental structure and are continually recapitulated, constituting a fundamental premise in American society for people of color.

According to the Wilson (2009),

> Forces that operate directly to advantage or disadvantage individuals and groups on the basis of race, and thus contribute to racial inequality, include two types—social acts and structural processes. Among the social acts are discrimination in hiring and promotion, housing, and admission to educational institutions, as well as exclusion from unions, employers' associations, and clubs. Systematic structural factors in this category of direct causes are laws, policies, and institutional practices that exclude people on the

> basis of race or ethnicity. These range from explicit arrangements, such as Jim Crow segregation laws, voting restrictions, and targeted policies, to more subtle institutional processes—e.g., school tracking along racial lines, racial profiling, etc.—whereby ideologies about group differences are embedded in organizational arrangements. (p.2)

The Black male constitutionally accrues less capital in all forms in a capitalistic society. For the Black male the potential, continually falls below the actual, brutality is often encountered in all facets of social life, as was in the case of the Negro males in the USPHS Tuskegee Study of Untreated Syphilis which commenced in 1932. As the literature uncovered, Black males are low on power, which encompasses the acquisition of varied social resources, including education, positive use of the health care system, the accrual of basic socioeconomic goods, and often encountering a negative confrontation from the criminal justice system. According to Airhihenbuwa and Linburd (2006),

> At the structural level of the political economy and racial inequality, African American men have the highest rates of unemployment and therefore are less likely to have health insurance; are overrepresented in the prison industrial complex (comprising more than 60% of persons under correctional supervision); have higher exposures to toxic substances in their living and work environments; and are at higher risk of occupationally induced diseases, injuries, and death. (p. 493)

Galtung (1969) conceptually described personal violence in comparison to structural violence, “as something that shows certain stability, whereas personal violence allows tremendous fluctuations over time” (p. 173). Galtung further compared personal violence to structural violence as an analogy to a physical violence paradigm akin to the perpetrator and abuse victim. Galtung (1969) analyzed,

> When one husband beats his wife there is a clear case of personal violence, but when one million husbands keep one million wives in ignorance there is structural violence…in a society where life expectancy is twice as high in upper classes than in lower classes, violence is exercised even if there are no concrete actors one can point to directly attacking others, as when one person kills another. (p. 171)

Another distinction made by Galtung (1969) which is really the first distinction of violence is between physical and psychological violence. Galtung denotes physical violence as working on the body with psychological violence as working on the soul; "where the latter would include lies, brainwashing, indoctrination of various kinds, threats, etc. that serve to decrease mental potentialities" (p.169).

In 1990, Galtung (1990) introduced the concept of cultural violence. In introducing cultural violence, Galtung (1990) expressed,

> … we mean those aspects of culture, the symbolic sphere of our existence-exemplified by religion and ideology, language and art, empirical science and formal science (logic, mathematics) and that can be used to justify or legitimize direct or structural violence (p. 291).

In contrasting the degree of detriment to direct, structural violence and cultural violence, Galtung (1990) articulated, "Culture violence makes direct and structural violence look, even feel, right – or at least not wrong" (p. 305).

The impact of cultural violence appears too massive according to Galtung (1990), "after some time, direct violence is forgotten, slavery is forgotten, and only two labels show up, pale enough for college textbooks: 'discrimination' for massive structural violence and 'prejudice' for massive cultural violence. Sanitation of language itself: cultural violence"

(p. 295). The theoretical construct presented in this context correlates with Calhoun and the necessity of a cultural framework or lens for a historical view of specificity.

A prospective view of structural violence requires historical reflection. Galtung (1968) surmised,

> One may argue that all cases of structural violence can, by closer scrutiny, be traced back to personal violence in their pre-history. An exploitative caste system or race society would be seen as the consequences of a large-scale invasion leaving a thin, but powerful top layer of the victorious group after the noise of fighting is over. A bully should be seen as the inevitable product of socialization into a violent structure: he is the rebel, systematically untrained in other ways of coping with his conflicts and frustrations because the structure leaves him with no alternatives. That structural violence often breeds structural violence and personal violence often breeds personal violence nobody would dispute–but the point here would be the cross-breeding between the two. In other words: pure cases are only pure as long as the pre-history of the case or even the structural context are conveniently forgotten (p. 178).

Conceptually structural violence is personal given the distinctive historical attributions and significance to a minority people. According to Galtung (1969), “manifest violence, whether personal or structural is observable” (p.172). Breeding theories as such often fail to answer the “how” relative to their existence. However, to further clarify peace theory, an intimate involvement and connection exists with conflict theory and development research.

Theoretical constructs associated with peace research, emphasizing structural, psychological and cultural violence provides a framework for analyzing problems of those associated with victimology, are historically impacted by institutionalized barriers associated with living on the margins of life. More specifically structures associated with inequities relative to healthcare, criminal justice, education and socioeconomics intersect with social determinants altering the quality of one's life, possibly taking away hope, leading to apathy and psychomotor retardation. The absence of peace is violence. Violent structures destroy, maim, cripple and prevent potentialities from becoming actualized. Systemic racism is covert, pervasive and subtle in approach, associated violence appears invisible, merciless and unyielding and with no obvious accountable actors to confront, but yet the destructiveness can cripple and destroy the productivity and creativity of generations. The invisibleness of systemic violence hides behind hegemonic (i.e. political, social, economic forces), which are oppressive in temperament.

Dubois and Critical Theory

Paradigmatically, the philosophy of Dubois centered on an interdisciplinary focus which is essential for an exploration of the complexity of issues relative to critical theory. Reiland (2006) stated,

> Dubois' interdisciplinarity, coupled with his accent on political economy and social theory and his consistent emphasis on race, gender, and class issues, make his work an ideal model for reconceiving and recreating critical theory of contemporary society.... (p. 746).

A critical theorist views the whole in relation to its parts. Social mores and the dominancy associated with acquiring social goods are multifarious and require an in-depth analysis and often are not popular in dialogue, given the root causes of existence. Reiland (2006) conveyed,

> One of the major themes of Dubois' discourse revolves around race and racism or, more specifically, the critical, systematic, and social scientific study of race and the political

> economy of racism. However, race and racism were only part of the problem that faced a dying humanity from Dubois' point of view. There were other important life-threatening and liberty-denying issues, some of them involving sexism, capitalism, and colonialism, among infinite others. But, no matter what issue Dubois critically engaged, it should be emphasized that his major preoccupation was ever the dialectic of oppression and liberation—which is to say, the central dialectic (and defining characteristic) of critical theory. (p. 734)

Dubois (1903) conceptualized the essence of marginality, realizing the double consciousness assumed by Black Americans in a European American patriarchal dominant society. Philosophically, Dubois was embraced as a radical democrat, evoking social thoughts from that perspective (Marable, 1995). According to Marable (2005), Dubois' philosophical underpinnings align tenets ascribed to Western Marxism embracing an antiracist ideology, "viewed today as structural racism, domestically and transnationally". Dubois perceived racism, "'the color line', as a fully global phenomenon, undergirded by a political economy of modern capitalism" (p. xxxi). Mydral (1944) embraced the analysis of Dubois in a typification of the racial caste system. Mydral (1944) found,

> The caste line—or, as it is more popularly known, the color line—is not only an expression of caste differences and caste conflicts, but it has come itself to be a catalyst to widen differences and engender conflicts. To maintain the color line has, to the ordinary white man, the 'function' of upholding the caste system itself, of keeping the 'Negro in his place.' (p. 667)

An interesting view of the paradigm associated with inferiority theory often embraced by Northern European Americans as perceived by Dubois is revealed by Marable (2005), in a commencement address in 1943 delivered at Florida Agricultural and Mechanical (FAMU) University. An expressed concern by Dubois brought a stern realization, which referenced,

> No matter what scientists may believe and philanthropists assert," [among white Americans as a group there existed] "a hard nucleus of opinion which believes that Negroes are inferior, that their advance is a threat not simply to the domination of the white race to civilization itself". These deep seated cultural patterns would be extremely difficult to reverse, regardless of scientific evidence to the contrary. (Marable, p. xxxiii)

Dubois' legacy is entrenched with the essence of "otherness" as well as wanting the complete acknowledgement of differences therewith associated with the root causes associated with marginality and the full acceptance of "us" from "them". Airhihenbuwa and Liburd (2006) posited,

> The legacy of Dubois is strongly anchored in his tireless efforts to address the location of racism and power in the discourse on African American identity. As an African American intellectual trained as a sociologist whose discursive projects were deeply philosophical, Dubois' central intellectual contribution to our understanding of human behavior is framing the question of African American identity and belonging. Indeed, identity and belonging were primary themes in his prophetic mantra that "the problem of the 20th century is the problem of the color line." (p. 494)

The intellectual thought and public agency of Dubois was conceptualized with tenets ascribed as Black Marxism resonating, "within the unique historical experiences and material interests of both blacks and American people in general" (p. xxxiii). Marable (2005) surmised the philosophical stance of Dubois regarding structural issues and the realization of the centrality of, “Racism being … at the core of every issue relative to power, economic production, culture and society” (p. 11). Marable (2005) conveyed, relative to the centrality of racism, Dubois posited, “It was only through the development of an antiracist politics that the real material needs of all oppressed people could be addressed (p. 11). According to Marable (2005), the philosophical thought was applied through many historical pieces inclusive of, *“Striving for the Negro People”, “The Souls of Black Folk”, “The Study of Negro Problems”, The Negroes of Farmville Virginia* and other narratives ascribing to the social ills of the epoch.

Marable (2005) postulated,

> Dubois was endeavoring to fashion a program and strategies for resolving problems of Negro life and thereby enhance progressive development of a Negro racial group plagued by the complexity interrelated effects on them of racial prejudice and economic exploitation by white folks and problematic orientations, and practices that had become characteristic of Negro social and cultural life in the United States that Dubois (among a number of Negroes) was convinced were inimical to the resolution of social problems affecting their lives and impairing their progressive social evolution. (p. x)

For Dubois’ social philosophical thought was not without controversy, which was evident by his choice to join the Communist Party in 1961. The application of praxis makes use of the essence of critical reflection; Dubois joined the Socialist Party in 1911. However, Dubois resigned from the Socialist Party in 1912 to support Woodrow Wilson’s presidential campaign, albeit, departing also, because of the party’s failure to address or contest white racism.

Marable (2005) conveyed, in Dubois’ final *Autobiography* an acknowledgement of factors which motivated an “enduring persistence of white racism”. Dubois reflected, “my faith [in education]…was based on the firm belief that race was based on widespread ignorance…I was not at the time sufficiently Freudian to understand how little human action is based on reason"…. (p. xxxiii).

In the *Philadelphia Negro: A Social Study* (1899), written by Dubois, the context of disparities situates the intersecting variables associated with health and healthcare, politics, socioeconomics and race, all encumbering social determinants of heath. In essence, the social determinants of health influence health and health care disparities, which impact health status.

The magnitude of the lacuna in the health of Northern European Americans in comparison to Black Americans transcends centuries, W.E.B. Dubois (1996) in 1899 surmised distinct and notable differences of the health status of the Negro in comparison to the European American in Philadelphia. Dubois (1996) conveyed,

> One thing of course we must expect to find, and that is a much higher death rate at present among Negroes than among whites. This is one measure of the difference in their social advancement…Therefore, when considering the health statistics of the Negroes we seek first to know their absolute condition rather than their relative status. We want to know what their death rate is, how it has varied and is varying, and what its tendencies seem to be: with these facts fixed, we must then ask "What is the meaning of a death rate like that of the Negroes of Philadelphia? Is it, compared with other races large, moderate or small?... Finally, we must compare the death rate of the Negroes with that of the communities in which they live, and thus roughly measure the social difference between these neighboring groups (p. 148).

The historical significance of the afore-referenced work is essential to understanding social intricacies today, inclusive of the social determinants of health and their intersections with hegemonic forces, social goods and the relationship to health inequities. Bobo (2000) sought the necessity to clarify in his analysis of the Philadelphia Negro, the significance of, “[the]force of prejudice and discrimination” and their relationship with “economic and political factors of the Negro residents living in the seventh ward, the highest concentration of Black Americans in the city” (p. 196). Bobo (2000) posited,

> I suggest that the sort of nuanced and organic view of how racial prejudice relates to and influences the structural positioning of Black Americans, as developed by Dubois in the Philadelphia Negro, is sorely needed. There are strong reasons to believe that the modern-day disadvantages of Black Americans in the labor market, in the housing market, in politics, in the educational arena, and in myriad forms of interpersonal social interaction with whites are strongly linked to modern forms of racial prejudice. While there are no doubt structural conditions and processes that facilitate the reproduction of racial inequality largely without regard to prejudice–that is wealth inequalities … prejudice is a constituent element in the modern reproduction of systematic racial inequality. (p. 196)

Bobo (2000) further contended, “negative racial attitudes are part of the problem of high unemployment faced by Black Americans” (p. 196). Negative stereotypical attitudes are often held of young Black men. These views were revealed when in-depth interviews were conducted with employers when seeking to fill positions requiring low-skilled labor productivity in the work place (Bobo, 2000). Bobo (2000), revealed results of a study done by the Urban Institute of unabashed discrimination of access to entry level positions of low-skilled Black Americans. This study revealed in one out of five audits, Northern-European Americans advanced further than the applicant who was Black, even though both races were equal in credentials, albeit with race being the exception. Differential treatment included: (a) the lack of being allowed to submit an application, (b) not being offered an interview, and (c) the failure of an offer of employment. Although not all Black applicants experienced unequal treatment relative to their Northern European American counterparts, in some instances the overall pattern was indicative of the favorability of the Northern European American three times higher over the Black American (Bobo, 2000; Turner, Fix & Struyk, 1991).

The continuation and persistence of negative acts of residential segregation is perpetual. According to Bobo (2000), "Hence, to find that prejudice both affects where whites prefer to live and constrains where blacks feel comfortable living suggests that prejudice exerts effects on black opportunity through the dynamics of the housing market" (p. 197). The significance of spatial mobility, according to a study by Farley et al. (1994), found an unwillingness of European Americans to negotiate residential living space with Black Americans. Bobo and Zubrinsky (1996) found that an unwillingness to share residential living space was also relative to Hispanic and Asian Americans, which was not reflective of social class or status.

Hence, the significance of social determinants is reflective in the afore-referenced findings from the previously discussed social theorists. Black Americans and other minorities are unduly penalized in a daily struggle of existence and survival in varied contexts. A perpetual struggle of hegemonic forces, social stratification and intersections in convoluted links as evidenced by dominancy in the accrual of social goods aligned to hierarchical positioning. The mere struggle of survival and the lack of equitable supportive social networks can influence trust, hope and quality of life of Black Americans.

The Origins of Critical Race Theory

Teranishi and Brisco (2008) posited that Critical Race Theory (CRT) is indicative of an emergence from inquiries of legal scholarship relative to the continuance of the perpetuation of race and racism in American society in spite of major gains associated with civil rights legislation in the1950s and 1960s. Persistent racial segregation in educational outcomes, equitable housing, the criminal justice system, health care access and other social goods; critical race theorists conveyed in American society, racism remained "insidious and powerful" in the 21st century (Guinier & Torres, 2002; Ladson-Billings & Tate, 1995; Solorzano & Yosso, 2002; Teranishi & Brisco 2008).

CRT has variant applications and theoretical constructs, with scholarly dictum reflecting: (a) the everyday occurrence of racism in American society, demystifying an anomalous or isolated occurrence, overlooked routinely, becoming the acceptable norm (Crenshaw, Gotanda, Peller & Thomas, 1995; Delgado, 1995; Delgado & Stefancic, 2001; Solórzano, 1998); (b) the history of racism in America and a contemporaneous view in society, masking the deeply embedded views through "meritocracy and objectivity", "racial neutrality" and "colorblindness" (Delgado, 1995; Guinier & Torres, 2002; Taylor, 2000; Teranishi & Brisco 2008); and (c)"race neutrality" which is challenged through the collective or accumulative "lived experiences" stories or narratives of people of color, evoking powerful tools of social realities which are counter narratives to dominant constructs (Crenshaw, Gotanda, Peller & Thomas, 1995; Delgado, 1995; Teranishi & Brisco 2008). Ford and Airhihenhuwa (2010), surmised, "CRT as a decentralized movement among scholars, researchers and activists that coheres around a set of tenets regarding racialization, marginalization and the role of critical race theorists (i.e., ‘crits’) in producing knowledge about societal inequities (p. 1390). Ford and Airhihenhuwa (2010), conceptualized,

CRT has at least four distinguishing characteristics. Racialization (i.e., racial phenomena, race, ethnicity and racism) are core tenets of CRT, encumbering social location. In framing CRT and the perceptions of marginalized groups, a conceptualization emanates as “centering in the margins”.

> To center in the margins … is to shift a discourse’s starting point from a majority group’s perspective, which is the usual approach, to that of the marginalized group or groups. The position of critical race theorists as ‘‘outsiders within’’ their respective disciplines is valuable in facilitating this process. (Ford & Airhihenhuwa, 2010, p. S31)

According to Ford and Airhihenhuwa (2010), scholarship reflective of critical race theory (CRT) has influenced race-based studies and phenomena since the 1980s, but limitation of application of this theory has been limited in public health and health related disparity research. Power, status and privilege of the dominant group, bequeaths social goods that lower ranking group members in the social hierarchy are not afforded. Entrenched legacies of difference endure, surmounting to racism in all of its forms and the perpetual stereotypical prejudices which unfairly define a lower ranking social group existence from the perceptual lens of the dominant group with paradigms of continual negativity. Ideological constructs of supremacy and property entitlement pervades centuries of distinct privilege while oppressing lower ranking groups. According to Bobo (2004),

> The defeat of Jim Crow racism and the victories of the civil rights era did not eradicate black-white economic inequality, labor market discrimination, or gargantuan disparities in accumulated wealth; they did not end residential segregation by race and randomly

> disperse people in physical space; they did not reallocate political power they did not completely repudiate the racists stereotypes and other elements of American political culture that feed… and sustain racism. These victories did, however, fundamentally restructure the terrain on which racism is now enacted, understood, and reproduced. (p. 34)

To say that race endures, however, is not to say that remains fundamentally the same and essentially unchanged. The much more demanding challenge is to account for how and why such a social construction comes to be reconstituted, refreshed and enacted anew in very different times and places. Bell (1992) contended,

> Black people will never gain full equality in this country. Even those Herculean efforts we hail as successful will produce no more than temporary ‘peaks of progress,’ short-lived victories that slide into irrelevance as racial patterns adapt in ways that maintain white dominance. This is a hard-to-accept fact that all history verifies. We must acknowledge it, not as a sign of submission, but as an act of ultimate defiance. (p.12)

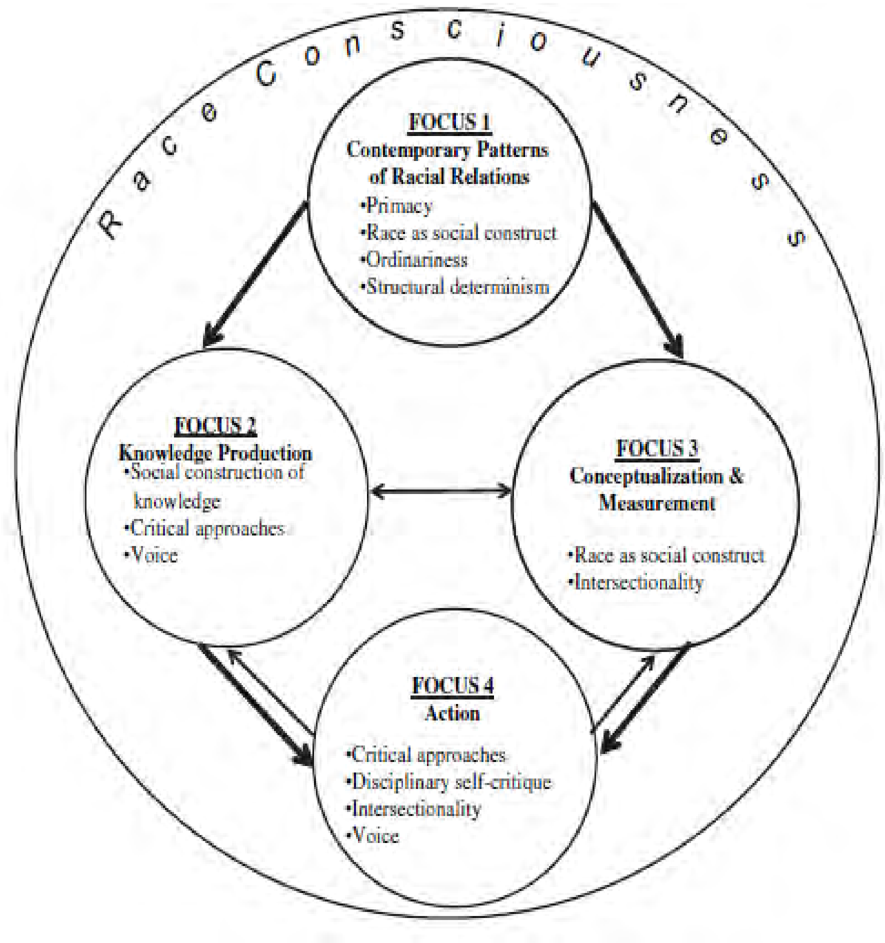
Mydral (1944) understood the construction of race and the endurance of racial bias against the “other”, the difficulty and impossible legacy of distinct “otherness” surmounting to the stationary position in the social hierarchy of ‘Blackness’. Mydral (1944) stated, “The Negroes meet greater difficulties in rising economically, educationally and socially. But even apart from this, they are kept as aliens permanently” (p. 620).

Public Health Critical Race Praxis (PHCR)

A variant form of CRT is Public Health Critical Praxis (PHCR) which has been recently constructed by Ford and Airhihenhuwa (2010; see Figure 4). The conduction of Public Health Critical Race Praxis (PHCR) is essential for the conduction of health equity research. To further clarify, Public Health Critical Race Praxis (PHCR) is indicative of maintaining the scientific rigor essentially required of high standards for conduction of public health's research. PHCR draws from the vigorous body of knowledge associated with antiracism work that exists outside of the field of public health (Ford & Airhihenhuwa, 2010). In contrasting CRT and PHCR, it is postulated, "Both CRT and PHCR attempt to move beyond merely documenting health inequities toward understanding and challenging the power hierarchies that undergird them. PHCR helps public health researchers to carry out health equity research with fidelity to CRT" (Ford & Airhihenhuwa, 2010, p. 1390).

The model of PHCR developed by Ford and Airhihenhuwa (2010) for health related disparities "aids the study of contemporary racial phenomena, illuminates disciplinary conventions that may inadvertently reinforce social hierarchies and offers tools for racial equity approaches to knowledge production" (p.1390). The focus of PHCR, as conceptualized by Ford and Airhihenhuwa (2011), encompasses ten principles with four focus areas (see Figure 4). The four focuses and 10 principles are of PHCR are listed in the following in an analysis by Thomas et al. (2011).

> (a) contemporary racial relations, guided by the principles of the primacy of race, race as a social construct, the ordinariness of racism, and structural determinism; (b) knowledge production, guided by the social construction of knowledge, critical approaches, and voice; (c) conceptualization and measurement, guided by race as a social construct and intersectionality; and (d) action, guided by critical approaches, voice, intersectionality, and disciplinary self-critique. (p. 408)



SOURCE: Ford and Airhihehenhuwa (2010)

Figure 4. Race consciousnesses, the four focuses and 10 affiliated principles.

PHCR aids in improvement, conceptualization and measurement of the effects of racism on health. A disciplinary awareness is promoted of ways that the field of public health or its conventions may unintentionally reinforce disparities. It is interesting that PHCR adds to the broader community of CRT, extending to social science and science based disciplines, with the centrality of racial equity in the relevance of health disparities. PHCR in actuality provides useful tools for the conduction of empirical research, allowing for pragmatic "application of critical race analysis" appropriate for useful interventions (p.1397). Ford and Airhihenhuwa

(2010), also posited relevance to the significance and usefulness of PHCR in the ongoing debate of a post racist society, "…, as is the case in the early 21st century, colorblindness is pervasive, PHCR can be useful for educating policymakers about specific ways that racial factors undergird ostensibly socioeconomic problems (e.g., limited access to healthcare)" (p. 1397). It is important to understand the significance of the changes of which race is conceptualized and constructed during epochal periods as a lens to review disparities.

Merton's Theory of Anomie

Social conditions can produce others in ways that are not conformed to societal norms or mores (Merton, 1938). Because social structures put forth demands upon particular social groups, abnormal, nonconforming and deviant behavior occurs. Such social groups and specific group members are "othered". Social location can induce nonconformist behaviors of varied characteristics, which are not biologically based, but occur in accordance to social strain (Merton, 1938). Merton (1938) articulated, "Aberrant conduct, therefore, may be viewed as a symptom of dissociation between culturally defined aspirations and socially structured means" (p. 38). Typically nonconformity leads to anomic behavior.

> The primary use of the word *anomie* is a social condition characterized by instability, the breakdown of social norms, institutional disorganization, and a separation between socially accepted goals and the available means for achieving them. Individuals living in a society in which this state of normlessness exists often experience alienation from other people and a loss of purpose in their lives. (New World Encyclopedia, Para III)

According to Zhao and Cao (2010) "…anomie is a product of the imbalance between the two fundamental components of society-cultural structure and social structure" (p. 1212). Social structure is not in isolation to the concept of anomie. Zhao and Cao (2010) surmised, "People

> at the bottom of the class structure … are more likely to suffer from strain and anomie … [a] culture of unlimited economic success exerts pressure to those to take the most efficient means to achieve monetary success (p. 1212).

The theory of anomie of which Merton ascribed originated from Durkheim's' conceptualization which was expanded and broadened. Durkheim invoked this concept in his description of the theoretical causes of suicidality. Durkheim conceptualized that when society is cohesive, there is less opportunity for alienation and isolation and less risk for suicidality. Durkheim constructed three social responses of suicidal realities, inclusive of: (a) egoistic, (b) altruistic and (c) anomic suicide. Egoistic suicide can occur when social supports are lacking occurring with less integration, cohesion and the lack of positive group dynamics which occurs in relationship to group memberships (i.e. family or church). Altruistic suicide occurs when an inordinate integration occurs. An association occurs with political, cultural and religious affiliation with loyalty that is worthy of self-sacrifice for the sake of the group. Anomic suicide occurs with life changes which cause disruption such as loss of intimate partners through divorce or loss of financial stability. A loss of sanctioned norms evokes feelings of an existence of separateness or feelings of isolation from the established cohesive group (Townsend, 2012).

> According to the New World Encyclopedia (2012) Durkheim… suggested that people need standards by which to live their lives. This allows them to achieve recognizable success by setting commonly valued goals that have socially acceptable means by which they can be achieved. When such standards are lost, socially recognizable success becomes impossible and people feel that their lives are futile. (Para I)

A lack of norms limits constructive behavior, allowing for insurmountable freedom, albeit the course can be altered in negative contexts. An existence devoid of direction and existence attacks positive agency. Such an existence can impact thoughts relative to suicidality, according to Durkheim as a means to end a life lacking positive goals.

According to Barr (2008),

> …deleterious effects that develop when an individual loses faith that the norms of society in which he lives will treat him fairly and equally with others, when society appears to hold out one normative message, yet reacts with another, an individual may come to distrust society and its systems of norms. In the face of a loss of normative faith, one tends to become isolated and alienated from the norms of society. In the face of such “social anomie”, it may be extremely difficult for a person born into a position of disadvantage (whether it be economic, social, or racial) to adhere to the behaviors identified by the norms of that society as leading to healthy outcomes. (pp. 55–56)

When a member of a disadvantaged class, one is more likely to experience alienation, powerlessness, as a result of these variables, lower educational levels, results in lower occupational status as well as lower income levels. DDHS (2001) posited,

> Poor neighborhoods have few resources and suffer from considerable distress and disadvantage in terms of high unemployment rates, homelessness, substance abuse, and crime. A disadvantaged community marked by economic and social flux, high turnover of residents, and low levels of supervision of teenagers and young adults creates an environment conducive to violence. Young racial and ethnic minority men from such environments are often perceived as being especially prone to violent behavior, and indeed they are disproportionately arrested for violent crimes. (p. 39)

Barr (2008) conveyed findings from data in 2002 which reviewed age adjusted death rates in the U.S. by race and gender. When educational attainment was utilized as a primary measure of SES, Black Americans did not surmount to the same levels in comparison to the European American counterparts. Findings revealed that by race and gender, death rates were substantially higher for Black Americans than their European American cohorts. A possible explanation revealed differences in educational attainment by race of the two social groups. Black Americans were less likely to have graduate or professional degrees, to never have graduated from high school, or to attend or graduate from college. When the median level of income was compared, by race and gender as measured by SES, Black men earned less across all levels of education, when compared to their European American male counterparts. It is interesting to note that even when European American males drop out of high school or earn a high school diploma, Black males earn 20 percent less than their European American counterparts with the same status. Females by race earned roughly the same incomes relative to educational attainment. A further analysis reveals that outcomes of health are not equated to similar income measures of SES according to Barr (2008). Death rates are persistently different when income measures are similar when comparing social groups. When reviewing findings in 1980 of income of the two social groups, Barr (2008) found,

> Those with lower incomes have higher death rates than those with higher incomes, with the ratio in the death rate of lowest income to highest income ranging from 2.4 to 2.9 at a given income, blacks die at a higher rate than whites, with the ratio ranging from 1.04 for higher income men to 1.65–1.67 in lower- and middle-income women. Even when we look at individuals with the same level of SES,…we see persisting differences in death rates with blacks dying more often than whites. (p. 32)

Barr (2008) surmised a continuous association of SES and health, with the increase of health status with each incremental increase in SES. According to Barr (2008) multiple forms of association exist in the analysis of SES and health, not just reflective of income, but are inclusive of education, occupation “and possibly an additional hierarchy of race” (p. 33).

Definition of Terms

The following terms were derived as the literature was explored. The essence and derivation of the meanings and their application provides clarity and relevance to the focus of this study as well as to the development of the theoretical and conceptual frameworks.

Absolute poverty: Poverty as defined in terms of the minimal requirements necessary to afford minimal standards of food, clothing, health care and shelter.

Access: Includes “rates of insurance coverage for adults and children and indicators of access and affordability of care” (Commonwealth fund.org).

Access to health care: “The timely use of personal health services to achieve the best health outcomes” (Agency of Healthcare Research and Quality, DATE, p. ??)

Accessible: the ease with which a patient can initiate an interaction for any health problem with a clinician (e.g., by phone or at a treatment location) and includes efforts to eliminate barriers such as those posed by geography, administrative hurdles, financing, culture, and language (IOM, 1994, p. 28).

Acute Care: Health may range from an acute, relatively minor, self-limited illness to a complex set of symptoms that could be life threatening, to a mental problem (IOM, 1994, p. 24)

Acute Disease: A short-term disease (such as influenza or pneumonia) from which a person either dies or recovers (Elwell, 2010, p.1). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Affect: Experiences pertaining to feelings, emotion, or mood (Sousa & Lyubomirsky, 2001, p. 669).

Agency: A self-perception moving along the pathway to goal achievement—the willpower to start something and to persevere in the goal journey.

Agrarian societies: Societies whose mode of production is based on agriculture (crop-growing) primarily through the use of human and animal energy. Also referred to as agricultural societies. (See also Traditional states.) (Elwell, 2010, p. 1). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Alabama Black-Belt: "Consists of a group of primarily agricultural counties, with dark rich soil, extending east to west across Central Alabama, that currently experience high rates of poverty, illiteracy and infant mortality… suffers from severe economic stagnation due to a lack of infrastructure and economic opportunities…the most economically depressed area in Alabama ….eight Black Belt counties are among the 100 poorest counties in the United States, and poverty rates in the Black Belt, generally, … twelve of these Black Belt counties in the poorest 13 percent of counties nationally…. Perform poorly in almost every statistical indicator and trail behind in almost every category …eight of Alabama's ten lowest scoring school systems on the Stanford Achievement Test between the years 1996 and 2001." Retrieved from http://blackbeltaction.alabama.gov/EO.aspx

Alabama Expanded Black Belt Designated Counties: The list of counties comprising the Black Belt is often dependent on the context but traditionally includes Barbour, Bullock, Choctaw, Crenshaw, Dallas, Greene, Hale, Lowndes, Macon, Marengo, Montgomery, Perry, Pickens, Pike, Russell, Sumter, and Wilcox. Sometimes the region is extended into the southern coastal plain to include Clarke, Conecuh, Escambia, Monroe, and Washington Counties. Retrieved from http://communityaffairs.ua.edu/blackbelt.html (Para 1 and 2).

Alienation: The sense that we have lost control over social institutions that we have created. Often characterized as estrangement from the self and from the society as a whole. Marx believed that general alienation was rooted in the loss of control on the part of workers over the nature of the labor task, and over the products of their labor (Elwell, 2010, p. 1). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Anomia: "A condition of anxiety and confusion that exists in individuals who are not given clear social guidance through social norms" (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Anomie: "A structural condition in which social norms are weak or conflicting" (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Anomie theory: "Robert K. Merton's theory of deviance which holds that many forms of deviance are caused by a disjunction between society's goals and the approved means to achieve these goals; also disjunction between society's goals and the approved means to achieve these goals; also called "structural strain theory" (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Capitalism: An economic system based on the private ownership of the means of production and distribution in which the goal is to produce profit (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Capitalist class: Those who own companies, or stocks and shares, using these to generate economic returns.

Census: A count of the population, often including a detailed profile of that population. Profits (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Class: Most sociologists use the term to refer to socioeconomic differences between groups of individuals which create differences in their life chances and power. Marx differentiates class by their relationship to the mode of production (owner/non-owner) (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Class consciousness: An objective awareness of the class system, including the common interests of people within your class (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Class system: Stratification is a “multidimensional phenomenon”; that is, populations are ranked along various dimensions such as occupation, education, property, racial-ethnic status, age, and gender. Each of these dimensions is a “class system.” According to Gerhard Lenski, class systems are “a hierarchy of classes ranked in terms of a single criterion.” Thus, “African-American” is a particular class within the American racial-ethnic class system, while “working class” is a particular class within the American occupational class system (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Cognitive: The mental process of knowing, thinking, learning, and judging (Sousa, & Lyubomirsky, 2001, p. 669).

Community: A group of people who share a common sense of identity and interact with one another on a sustained basis (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Concept: Any abstract characteristic that can potentially be measured (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Conflict: A clash of interest (sometimes escalating to active struggle) between individuals, groups or society (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Conflict theory: Sociological theory that emphasizes the role of power, authority, and manipulation in sociocultural change and stability (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Crisis medicine: Medical treatment that focuses on curing illness (as opposed to preventing the occurrence of disease) (Elwell, 2010, p. 2). Retrieved from http://www.faculty.rsu.edu/users/f/felwell/www/glossary/Index.htm

Critical theory: “An approach to viewing the world that involves a critique of society, with a goal of envisioning new possibilities and effecting social change.”

Crude birth-rate. A statistical measure representing the number of births per thousand population within a given year.

Crude death-rate. A statistical measure representing the number of deaths per thousand population that occur annually in a given population.

Culturally Sensitive Care: “The ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic, or cultural heritage” (U.S. Department of Health and Human Services, Office of Minority Health, 2001, p. 131).

Culture. The values, norms and material goods shared by a given group … symbolic aspects (values and norms).

Culture of poverty. The view that the poor have a different value system that contributes to their poverty.

De facto segregation: Without legal basis but sanctioned by custom or practice (Krieger, 1999, p. 297).

De jure segregation: The separation of social groups by law. Examples of *de jure* discrimination include Jim Crow laws, now overturned, that denied African Americans access to facilities and services used by white Americans (Kreger, 1999, pp. 57–111).

Deviance: Behaviors which do not conform to significant norms held by most of the members of a group or society. What is regarded as ‘deviant’ is highly variable across societies.

Deviant behavior: Actions or behaviors that violate cultural norms.

Deviant community: A group specifically organized around a form of social deviance.

Deviant identity: A person’s self-identification as a deviant.

Deviant subculture: A subculture which has values and norms which differ substantially from those of the majority in a society.

Discrimination. The denial of equal access to social resources to people on the basis of their group membership. …a socially structured and sanctioned phenomenon, justified by ideology and expressed in interactions, among and between individuals and institutions, intended to maintain privileges for members of dominant groups at the cost of deprivation for others. (Krieger, 1999, p. 301)

Discrimination: … all means of expressing and institutionalizing social relationships of dominance and oppression. At issue are practices of dominant groups to maintain privileges they accrue through subordinating the groups they oppress and ideologies they use to justify these practices, with these ideologies revolving around notions of innate superiority and inferiority, difference, or deviance (Krieger, 1999, p. 301).

Disparities: Differences that are indicative of injustice or unfairness (LaVeist, 2005, p. 11).

Dissimilarities: “Differences that are not attributable to injustice or unfairness (LaVeist, 2005, p.111): Differences across racial and ethnic groups in health conditions, risks, and prognoses” (LaVeist, 2005, p. 54).

Economy. The organization of production and distribution of goods and services within a sociocultural system.

Education. The transmission of knowledge to members of society. The knowledge passed on is in the form of technical and cultural knowledge, technical and social skills, as well as the norms and values of the society.

Education system. The system of formalized transmission of knowledge and values operating within a given society.

Equity: “Differences in performance associated with patients’ income level, type of insurance, or race or ethnicity” (Commonwealth fund.org).

Faith-Based Communities: “A community connected and centered in faith, reaching out to the people of that community – the Church as a faith based community reaches out beyond the walls impacting lives …” (Personal communication – Dr. Clifford Jones, Pastor, Greater Peace Missionary Baptist Church, Auburn, Alabama)

False consciousness. Marxian concept that refers to the ideology of the subordinate class which has been largely fashioned by the ideology and control of the elites within a society.

Family. A group of individuals related to one another by blood ties, marriage or adoption. Members of families form an economic unit, the adult members of which are responsible for the upbringing of children. All societies involve some form of family, although the form the family takes is widely variable. In modern industrial societies the main family form is the nuclear family, although a variety of extended family relationships are also found.

Functionalism. A theoretical perspective that focuses on the way various parts of the social system contribute to the continuity of society as well as ~~the~~ affect the various parts have on one another.

Gender. Socially defined behavior regarded as appropriate for the members of each sex.

Gender gap. Political term referring to the gap between men and women on political attitudes and behavior.

Gentrification. The renovation of poor and working class urban neighborhoods and the displacement of the original residents.

Ghetto. A section of a city occupied predominantly by members of a single racial or ethnic group, usually because of social or economic pressure.

Government. Formal institutional structures of the nation-state that attempt to regulate internal and external relations.

Health Care Disparities: “Differences in access, utilization, quality of care or outcomes from use of health care services (LaVeist, 2005, p. 54).

Health Disparities: Differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes (LaVeist, 2005, p. 3).

Health inequalities: sometimes used interchangeably with the term health disparities, is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity).

Health inequities: A subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair (LaVeist, 2005, p.109).

Health Status Disparities: Differences in the incidence of prevalence of disease, disability or illness. These differences can be among racial, ethnic groups, gender groups, socioeconomic groups or other groupings (LaVeist, 2005, p. 109).

Health status: …physical, mental, and social function. Although health status is largely determined by environmental and personal variables, health services should, to the extent possible, contribute to improved health status (IOM, 1994, p.19).

Hegemon: The predominant political, economic, or social influence of a nation-state over others.

Hidden curriculum: Behavior or attitudes that are learned at school but which are not a part of the formal curriculum. For example, aspects of classism can often be "unintentionally" conveyed in learning materials.

Higher education: Usually refers to education beyond high school level, often in colleges or universities.

Hope: "A state of being characterized by anticipation for a continued good state, an improved state or a release from a perceived entrapment. The anticipation may or may not be founded on concrete, real world evidence. Hope is an anticipation of a future that is good and is based upon mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, and a sense of “the possible” (Miller, 1986, p. 52).

Infant mortality rate: The number of infants who die during the first year of life, per thousand live births.

Institution: An established pattern of human social behavior in a given society—such as marriage, family, or government.

Institutional discrimination: Accepted social arrangements that place minority groups at a disadvantage.

Institutional racism: Accepted social arrangements that exclude on the basis of race.

Institutionalization: The embodiment of widespread norms, beliefs, and values into social structures, laws, and formal codes of conduct.

Integration: Incorporating disparate parts within the whole. The bringing of people of different ethnic groups into equal association.

Interpersonal Trust: “The acceptance of a vulnerable situation in which the truster believes that the trustee will act in the truster’s best interest” (Thom, Hall & Pawlson, DATE, p. 124).

Jim Crow - The colloquialism that refers to the Southern pattern of racial segregation.

Law: Written rules established by a political authority and backed by government.

Life-satisfaction: “The degree to which a person positively evaluates the overall quality of his/her life as-a-whole. …how much the person likes the life he/she leads” (Veenhoven, 1996, p. 6).

Life-span. The maximum length of life that is biologically possible for a member of a given species.

Literacy: The ability of individuals to read and write.

Local knowledge: Knowledge of a local community possessed by individuals who spend long periods of their lives in them.

Longevity: A long duration of life or, a long tenure in an organization.

Marxism: Contemporary social theory deriving its main elements from Marx's ideas. Marxist theory strongly emphasizes class struggle and material causation.

Medicaid. Government program (federal and state) to provide medical care to the poor.

Medicare. Government health insurance for those over sixty-five.

Middle class. A social class broadly defined occupationally as those working in white-collar and lower managerial occupations; is sometimes defined by reference to income levels or subjective identification of the participants in the study.

Minority group. A group of people who are defined on the basis of their ethnicity or race. Because of their distinct physical or cultural characteristics, they are singled out for unequal treatment within a society.

Mortality rate. The number of deaths that occur in a particular population in a specified period of time (usually a year).

Norms. Rules and expectations of conduct which either prescribes a given type of behavior, or forbids it.

Patient. …Individual who interacts with a clinician either because of real or perceived illness or for health promotion and disease prevention (IOM, 2004, p. 18)

Policy research. Social research aimed at clarifying issues and problems that can then be addressed by changes in social policy.

Politics. Attempts to influence governmental activities.

Population. In social research this term refers to the total group of people that the researcher is studying. For very large groups, sampling is usually undertaken.

Poverty line. The amount of income that it takes to maintain a family at a basic level. This amount is often determined by government.

Power. The ability to achieve aims or further the interests you hold even when opposed by others.

Pre-industrial societies. A broad classification of all modes of production that came before industrialism. The most common of which are Hunting and gathering, Horticultural, Pastoral, and Agrarian.

Prejudice. The holding of unfounded ideas about a group, ideas that are resistant to change.

Prestige. Social respect accorded to an individual or group because of the status of their position.

Primary deviance. The deviant act itself, the violation of a norm.

Primary group structure. A term used in sociocultural materialism to refer to structural groups in which members tend to interact on an intimate basis. They perform many functions such as regulating production, reproduction, socialization, education, and enforcing social discipline. Examples include family, community, voluntary organizations, and friendship networks.

Primary group. A typically small group of individuals standing in an enduring personal relationship to one another—examples would include parents, spouse, or close friends.

Primary labor market. The term refers to the economic position of individuals engaged in occupations that provide secure jobs, and good benefits and working conditions.

Primary needs. A term used by Karl Marx to refer to natural needs that we are born with rather than learn; this would include such needs as food, water, and shelter.

Private health care. Fee-for-service health care available only to those who pay the full cost of them.

Professions. Occupations requiring extensive educational qualifications, with high social prestige, subject to codes of conduct laid down by central bodies.

Proletariat. Marxist term that refers to the class of industrial workers who have nothing to sell on the free market except their labor~~.~~

Quality of Life: "An individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns" (The WHOQOL Group, 1995, p. 1405).

Racial profiling. The use of race as the primary criteria to decide whether or not to subject an individual to more intensive scrutiny on the part of agents of social control (such as police, or airport security).

Racism. Attributing inferiority to a particular racial category. Racism is a specific form of prejudice focused on race.

Racism: A "system of advantage based on race" is a pervasive aspect of U.S. socialization. It is virtually impossible to live in U.S. contemporary society and not be exposed to some aspect of the personal, cultural, and/or institutional manifestations of racism …in our society (Tatum, 1992, p. 3).

Racism: those practices and ideologies, carried out by structures, institutions, and individuals that reproduce racial in-equality and systematically undermine the well-being of racially subordinated populations (Pulido, 2000, p.10).

Radical movements. Social movements that seek fundamental change in the sociocultural system.

Religion. A set of beliefs involving symbols regarded as sacred, together with ritual practices in which members of the community engage.

Religiosity. A measure of the intensity and importance of religious faith to an individual.

Retreatism. Robert K. Merton's Anomie Theory category consists of society's dropouts: psychotics, tramps, and substance abusers. They have given up on both the culturally prescribed means and the goals. Merton viewed it as a way of escaping society's demands.

Rural:

Fringe: Census-defined rural territory that is less than or equal to 5 miles from an urbanized area, as well as rural territory that is less than or equal to 2.5 miles from an urban cluster.

Distant: Census-defined rural territory that is more than 5 miles but less than or equal to 25 miles from an urbanized area, as well as rural territory that is more than 2.5 miles but less than or equal to 10 miles from an urban cluster.

Remote: Census-defined rural territory that is more than 25 miles from an urbanized area and is also more than 10 miles from an urban cluster.

Social causation. "Exposure to low SES leading to worsening of health status (LaVeist, 2005 p. 173).

Social class. Most sociologists use the term to refer to socioeconomic differences between groups of individuals which create differences in their life chances and power.

Social construction. A theoretical perspective that explains most social behaviors as created and learned within a cultural, social, and historical context.

Social Darwinism. An early and now largely discredited view of social evolution emphasizing the importance of “survival of the fittest” or struggle between individuals, groups, or societies as the motor of development. Social Darwinism became widely popular in the latter half of the nineteenth century and was often used to justify existing inequalities.

Social institutions. Major structural entities in sociocultural systems that address a basic need of the system. Institutions involve fixed modes of behavior backed by strong norms and sanctions that tend to be followed by most members of a society.

Social issues. Problems that are the result of the institutional structure in a society; these problems usually affect large numbers of people and are experienced as individual problems. Examples in modern American society include divorce, poverty, and immigration.

Social justice. The fair administration of laws without regard to ethnicity, sexual orientation, gender, religion, or class.

Social location. An individual’s or a group’s position within a social hierarchy (e.g., privileged vs. marginalized, minority vs. majority) and informs the perspectives from which one views a problem (Ford and Airhihenbuwa, 2010)

Social role: The expected patterned behavior of an individual occupying a particular status position.

Social selection. “Poor health status leading to lower SES” (LaVeist, 2005, p.173).

Social stratification: Structured inequalities in life chances between groups in society. These inequalities are relatively fixed; individuals within each broad group have similar attitudes, beliefs, and backgrounds.

Social structure: The pattern of human relationships formed by human groups and institutions within a given society.

Socialization: The lifelong processes through which humans develop an awareness of social norms and values, and achieve a distinct sense of self.

Society: A society is a group of people who live in a particular territory, are subject to a common system of political authority, and share a common culture.

Sociocultural system: Material, structural, and cultural elements that make up the total system.

Socioeconomic status (SES): A frequently used measure of class determined by some combination of income, occupational prestige, and years of education.

Stereotype. A rigid and inflexible image of the characteristics of a group. Stereotypes attribute these characteristics to all individuals belonging to that group.

Stratification: The existence of structured inequalities in life chances between groups in society.

Structural Violence: the increased rates of death and disability among those who occupy the lowest rungs of the class systems in unequal societies result from the choices made both by individual countries and the world community regarding allocation of resources. Under such a construct, a relatively few receive incredible riches, while the vast majority suffers without. The forces that contribute to structural violence are complex and largely invisible. As such, they receive little attention from world leaders, the American press corps, and our rather undiscerning populace (O'Neil, 2009, p.118)

Structure: Sociological term to refer to all human institutions, groups and organizations

Subjective Well-Being: "An evaluation of one's life assessed by measures of global life satisfaction, frequency of positive affect, and frequency of negative affect" (Sousa & Lyubomirsky, 2001, p. 669).

Traditional states: Societies in which the production base is agriculture or pastoralism.

Trust: "The willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party" (Mayer, Davis & Schoorman, 1995, p. 712)

Wealth: "Accumulated value of all assets, including home equity, the value of savings and checking accounts, retirement accounts, stocks and mutual funds, rental property, business, and vehicles (LaVeist, 2005, p.169).

Research Questions

The following research questions were investigated:

1. What is the level of Trust in the Healthcare System as measured by the LaVeist Medical Mistrust Index (MMI) V2.2 scale?

2. What is the level of Hope as measured by the Hendricks/Murdaugh/Hendricks Hope (H2HM Scale)?

3. What is the quality of life satisfaction as measured by the Endicott Short Form General Activities subscale of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)?

4. What is the relationship of trust in the Health Care system and Hope to quality of life satisfaction among adults in Alabama's Expanded Black Belt?

Limitations

1. Participants were limited to one area only – the Southeast District, ~~in~~ a faith-based community.
2. The instruments reflect perceptual measures only which impact reliability in comparison to objective measures.
3. Responses might not be stable over time and therefore the P.I. will only measure from a certain point in time.
4. The study was limited to adults living in the extended Black Belt counties and were majority Black American; therefore generalizations should be done with caution.
5. Very sparse representation of members from the dominant group were representative, in this study. Generalization would proceed with caution.
6. Participants from the sample were primarily healthy, without perceived terminal illness, unless self reported.

Organization of the Study

Chapter II includes a review of the literature which is related and supports the significance and relevance of the study. Chapter III presents the methods and approaches that were used to collect the data as well as an empirical evaluation of the collected data. Chapter IV discusses results of the study, a description of the sample with analysis of the research questions. Chapter V depicts findings of the study, limitations and implications for future research.

CHAPTER 2: LITERATURE REVIEW

For the wound of the daughter of my people is my heart wounded; I mourn, and dismay has
taken hold of me. Is there no balm in Gilead? Is there no physician there?
Why then has the health of the daughter of my people not been restored?
O that my head were waters, and my eyes a fountain of tears, that I might weep day and night
for the slain of the daughter of my people! Jeremiah 8:21-22, 9:1

Of all the forms of inequality,
injustice in health is the most shocking and most inhuman.

The Rev. Martin Luther King, Jr.
Second Annual Convention of the Medical Committee for Human Rights,
Chicago, March 25, 1966

When interpreting the impact of the health care system through a historical lens for people of color, the reality of the existence of racism in the healthcare marketplace cannot be interpreted as an isolative factor. According to Carter-Pokras, Lie, and Núñez (2008), “Racism and discrimination have played an important historic role in the United States in limiting access to health care for African Americans and other racial/ethnic minority groups” (p.13). Black Americans have a historical legacy of mistrust as a minority group; however, Native Americans also, endured inhumane treatment across the American landscape. The U.S. Commission on Civil Rights (2004) substantiated the malevolent attack of Native Americans in the American society,

> A long history of disenfranchisement; extermination of tradition, language, and land rights; broken treaties; sterilization of Native American women; placement of Indian children in Indian boarding schools; and other experiences of oppression have

> established a deep-rooted intergenerational anger, intergenerational grief, and mistrust of government that persists to this day. Clearly, this mistrust and these feelings of resentment are not unfounded. (p.28)

The legacy of mistrust bears a critical perception of some social groups, in modern day America particularly so for people of color. The Sullivan Commission (2004) posited,

> Contemporary health crises are also plagued by this mistrust. A 1990 survey conducted by the Southern Christian Leadership Conference found that 35 percent of the 1,056 black church members who responded believed that AIDS was a form of genocide. Many blacks, including prominent African Americans, believe that the disease comes from a man-made virus intended for use against minorities and other unwanted populations. Mistrust can interact with cultural beliefs, rendering alternative theories of disease causation credible. (p. 23)

Historically, Black Americans exhibit mistrust in the health care system due to a multiplicity of factors, including access, historical segregation in hospitals with less than courteous treatment by personnel. The DDHS (2001) asked a challenging question relative to a mistrust with an objective response. DDHS (2001) postulated,

> What are the reasons behind the lack of trust? Mistrust of clinicians by minorities arises, in the broadest sense, from historical persecution and from present-day struggles with racism and discrimination. It also arises from documented abuses and perceived mistreatment, both in the past and more recently, by medical and mental health professionals. (DHHS, p. 29)

Medical personnel have a unique history in the treatment of Black Americans. Garnering a history of chattel slavery, post-Civil War, the Freedman’s Bureau was instituted to provide service and medical supplies to former slaves. However, during the Post-Reconstruction period, exclusion of health care for Black Americans occurred either by discrimination or prohibition. Racist ideologies during the 1960s, and beyond, inhibited health care measures to Black Americans either through exclusion of presence from predominantly Black communities and institutions or by instituting policies resulting in limited access of Black American in the healthcare marketplace.

When medical mistrust is problematic, a failure or a delay in seeking appropriate health care can occur, with noncompliance with treatment regimens which compromises health status and health outcomes (LaVeist, Isaac & Williams, 2009). The underutilization of health care by Black Americans has been puzzling to researchers and social scientists.

It has been theorized that Black Americans have a distrust of the health care system, perhaps predisposed from egregious experimental and non-therapeutic acts throughout history. In essence, according to Washington (2006), experimental procedures and the suffering of Black Americans, relegated from the context of an experimental posture includes a cornucopia of acts which are inclusive of: (a) trauma, (b) profound deception, (c) injection with deadly agents, (d) stolen fertility, (e) disfigurement, (f) undignified body display, (g) chronic illness, (h) intractable pain, and (i) death. To further elucidate, Washington (2006) stated, “The experimental abuse of Black Americans is not an anomaly”; but “simply mirrored in the medical arena the economic, social and health abuses that the larger society perpetuated against people of color, especially the slave holding states” (p. 56). To give further credence to experimental abuses, validity is established in many documented accounts. According to Byrd and Clayton (2002), John Hopkins is noted for taking tissue samples from the cervix of Henrietta Lacks, a 31-year-old Black American female who had “ceaseless vaginal bleeding”.

Interestingly, Mrs. Lacks' cervical cancer cells had the ability to very aggressively multiply and flourish outside of her body without the usual methods of delicacy and coddling required for survival.

HeLa cells became world-renowned and sold to laboratories, advancing research agendas in molecular biology, cancer, the conquest of poliomyelitis and viral research. The specialty of garnering a cell-line culture was added to the expertise of a Caucasian researcher at John Hopkins, Dr. George Gey, who capitalized on the peculiarity of Mrs. Lacks' cellular properties. The gravity of the case of Mrs. Lacks substantiates another abuse of victimization. In this case, Mrs. Lacks' cells were taken without the permission of she or her husband. The HeLa cells distribution has industrially made millions of dollars, with Mrs. Lacks' family not realizing any of the fortune gained by the abuse of a wife and mother (Alford, 2012). According to Byrd and Clayton (2002), in a 1994 interview with Mr. David Lacks, husband of Mrs. Henrietta Lacks, a statement was made concerning the abuse and exploitation experienced: "As far as them selling my wife's cells without my knowledge and making a profit—I don't like that at all… They are exploiting both of us" (p. 286). Alford (2012) stated, "…[HelaCells]have been used in more than 60,000 experiments involving leukemia, Parkinson's disease and AIDS. The use of Hela cells have advanced cloning, gene mapping and invitro fertilization (Alford, 2012). Descendants of Mrs. Lacks have also had blood drawn without their consent according to Alford (2012). Medical ethicists would argue that in the time era of which Mrs. Lacks lived, informed consent was not an established protocol, at an academic medical center, and that Mrs. Lacks signed a surgical consent. However, in the 21st century informed consent has to be obtained for the use of tissue samples. "Unjust enrichment" is the term that is used to quantify others profiting for the use of HeLa cells, while family members of Mrs. Lacks live a very parsimonious lifestyle, albeit not by choice, by social restraints and conditions. HeLa cells have been used globally in research. While some social theorists would argue that given the epochal period of which the incident occurred, consent did not have to be obtained which was the legal custom (Alford, 2012).

The socio-historical features of the potential of mistrust is further clarified and prefaced by Washington with credence to the legacy and background of a profound problem. Washington (2006) posited,

> The experimental exploitation of Black Americans is not an issue of the last decade or even the past few decades. Dangerous involuntary and nontherapeutic experimentation upon Black Americans has been practiced widely and documented extensively at least since the 18th century. (p. 7)

According to Williams, Mourey and Warren (1994), “the study of racial differences in health has a long, and at times, disturbing history and its associated racist beliefs developed in the context of slavery and imperial colonialism (p. 27). Pamies and Nsiah-Kumi (2009) posited, “Racial and ethnic differences in health status, health care, and health outcomes have existed for centuries. During the slavery era, individuals were considered property and suffered unhealthy living conditions and their consequences” (p. 1).

Gamble (1997) posited an enduring legacy of mistrust commenced during the 18th century, when experimentation occurred to slaves. Pinn (2011) provided a historical chronology of medical experimentation without consent of the subjects to include the following incidents: (a) John Brown, an escaped slave who was subjected to painful experimentation by Dr. Thomas Quinn during the 1820s–1830s, (b) Dr. James Marion Sims, used children for Tetany experiments in the 1840s, (c) a 1929 Supreme Court ruling authorized of sterilization poor women, (d) a 1960 sterilization campaign was endorsed by the U.S government in Puerto Rico, (e) cancer cells were injected into elderly patients to determine the infectivity of the disease in 1963 at a Jewish hospital in New York, (f) hysterectomies done at an excessive rate in Northern and Southern states known as "Mississippi appendectomy" on Black females. In order to allow medical residents the opportunity to practice surgical techniques in Boston, involuntary hysterectomies were done in the 1970s, and (g) involuntary drug testing for cocaine occurred to Black females in the1980s and 1990s. In addition, the Willowbrook study occurred from the mid-1950s through the very early 1970s for a period of over twenty years. Children who were mentally retarded were injected with hepatitis (Krugman 1986).

Other writers document other non-therapeutic experiences which occurred to Black Americans. Harris, Gorelick, Samuels and Bempong (1996) revealed a historical and enduring legacy of mistrust of Black Americans from acts which were travestying. Southern Blacks became a prime source for medical school dissection experiments and autopsy specimens. Fearful of this practice, some expressed the hope to die in the summer months when dissection classes were not in session. This practice continued in the post-bellum South in the form of 'night-doctors' who stole and dissected the bodies of blacks (p. 631).

Riverby, while continuing her work with the USPHS Tuskegee Syphilis study uncovered documents that another unethical study had by sanctioned by the USPHS. The Presidential Commission for the Study of Bioethics (2011) provided the following analysis of the 1940s USPHS Guatemala "syphilis inoculation project." The studies encompassed research on three STDs—syphilis, gonorrhea, and chancroid—which also involved the intentional exposure to STDs of 1,308 research subjects from three populations: prisoners, soldiers, and psychiatric patients. Of the 1,308 subjects exposed to a STD, the researchers documented some form of treatment for 678 subjects. Commercial sex workers, who in most cases were also intentionally infected with STDs, were used to transmit disease. In addition, to improve diagnostics, the researchers conducted diagnostic testing of 5,128 subjects including soldiers, prisoners, psychiatric patients, children, leprosy patients, and Air Force personnel at the U.S. base in Guatemala. This diagnostic testing, which included blood draws as well as lumbar and cisternal punctures, continued through 1953 (p. 6).

Many studies cite the legacy of Tuskegee with inhibiting proper healthcare agency of Black Americans in various realms of the healthcare sector. It is speculated that the legacy of the study continues to hinder the relationship of Black Americans in the biomedical professions, and in more in specific areas of: (a) routine preventive care, (b) participation in clinical trials, and (c) organ donation requests (The Final Report of the Tuskegee Syphilis Legacy Committee, 1996).

According to Gamble (1997),

> The Tuskegee Syphilis Study continues to cast its shadow over the lives of Black Americans. For many black people, it has come to represent the racism that pervades American institutions and the disdain in which black lives are often held. But despite its significance, it cannot be the only prism we use to examine the relationship of Black Americans with the medical and public health communities. The problem we must face is not just the shadow of Tuskegee but the shadow of racism that so profoundly affects the lives and beliefs of all people in this country. (p.1773)

A structural analysis of contemporary society in the U.S today reflect inadequacies and inequities in the health care system, including:

> (a) layoffs of recently hired African-American physicians, (b) not having physicians on staff who can accept Medicaid patients, (c) requiring pre-admission deposits as a condition of obtaining care, (d) physicians refusing to participate in programs for low-income patients not eligible for Medicaid and accepting only patients of physicians with staff privileges, and (e) unavailability of services in a community. (pp. 13–14)

Other issues in the 21st century which evoke uneven and inequitable health care in rural and inner city communities include hospital closures of those serving Black communities and other minority patients or becoming privatized, and patient dumping despite legislation. Black Americans are not the only minorities to receive inequitable treatment, having unique and different experiences relative to their cultural tradition, more specifically in this instance are American Indians and Alaska Natives (p. 14).

Crisis in the 21st Century of the American Health Care System

The United States Health Care System while perceptively attractive to access, high standards technological innovations, in reality its citizens in comparison to other countries with considerable rank, fairs relatively poor in health outcomes, life expectancy, potential years of loss, high expenditures, appearing to fall in rank closer to the lower third of countries. Substantial reform has a propensity to reduce the health disparity by increasing access, reducing cost, improving health quality and the health status of all Americans. In 1991, it was evident that America was in the midst of a national health care crisis. Overall, the health care crisis was conceptualized as one of access, costs and financing. The “mainstream” health care crisis encompassed: (a) inordinate cost inflation, (b) a system which consumed 14 percent of the gross domestic product (GNP), (c) a budget of $800 billion in 1992, by 1994 exceeding $1 trillion, (d) 37 million constituents uninsured, and (e) with 40 to 50 million of Americans underinsured (Byrd & Clayton, 2000). Bayer, et al. (2007) postulated, “The American health system is by far the wealthiest, most expensive, most resource intensive, and, —after many failed attempts to achieve universal access—the most willfully inegalitarian health care system in the democratic world” (p.168).

Opinion polls conducted in 1994 indicated that 75% of American citizens revealed that the health care system necessitated fundamental changes and 84% revealed that a state of crisis existed (Kenagy, Berwick, & Shore, 1999). According to King, Ledford, Lambrew, Rothman and Podesta (2008), the Institute of Medicine (IOM) conveyed that approximately 100,000 deaths occur per year due to iatrogenic errors and injuries to patients while hospitalized. The Institute of Medicine (IOM) (2008) stated, “Between the health care we have and the care we could have lies not just a gap, but a chasm” (p. 1).

The IOM (2008) posited of the need for fundamental reform of the health care system to ensure that care is provided to all Americans that is: “(a) safe, (b) effective, (c) patient centered, (d) timely, (e) efficient, and (f) equitable” (p. xi). According to Thompson, Mitchell and Williams (2006), in the 21st century there exists a prevailing concern of key problematic areas in the health care system, bearing significant and distinct inequities, specifically for racial and ethnic minorities, the poor and other disadvantaged groups who reside in the US, with health care consumption being inadequate and severely worse than other members of the population.

Health care disparities prevail. According to the Agency for Healthcare Research and Quality (2009), barriers to care are still a problematic area for many American citizens. In comparison to urban residents, individuals residing in rural areas can more than likely be uninsured and for those who are insured it is likely that some will be underinsured. “Furthermore, rural residents with group insurance are more likely to have fewer benefits and higher out-of-pocket expenses, suggesting a higher rate of underinsurance" (Agency for Healthcare Research and Quality, 2009, p. 274). Having a regular provider of care promotes continuity, coordination and quality care. "…a usual primary care provider (a doctor or nurse from whom one regularly receives care) is associated with patients' greater trust in their provider and with good provider-patient communication" (Agency for Healthcare Research and Quality, 2009, p. 274). Multiple variables are evident in the US health care crisis. The social determinants of health influence health outcomes evoking either positive or negative conjectures. The WHO (2008) posited,

> Access to and utilization of health care is vital to good and equitable health. The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants. Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to people's access to, experiences of, and benefits from health care. (p. 8)

Access to the health care system particularly presents barriers for the uninsured. According to Arrow et al. (2009), 70 percent of Americans lack health insurance. Individuals that are uninsured often report use of fewer health care services with continued problems associated with costs and access (Institute of Medicine IOM, 2008). Cost containment, quality care and access is impeded by fragmentation that results from the millions of underinsured and uninsured Americans.

> According to the Census Bureau’s 2011,
>
> Current Population Survey (CPS), [indicated]there were 49.9 million uninsured individuals in 2010, or 16.3% of the total population. Those that lack insurance are a diverse group. Understanding the uninsured population is important for policy makers looking to design solutions to the problem. (DHHS ASPE ISSUE BRIEF Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey, Para I)

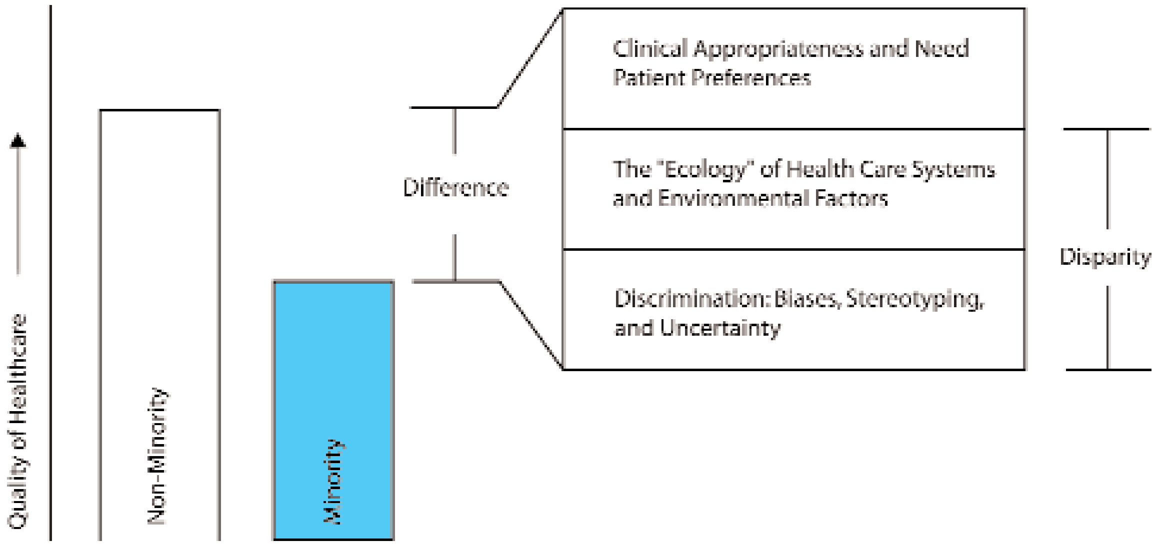
Obama (2007) conveyed that 47 million Americans were uninsured in 2007. Jonas and Kovner (2011) further clarified, in 2009, approximately 50.7 million Americans lacked insurance coverage; in addition, there were millions of individuals who were insured who had inadequate coverage. According to the U.S. Census (2010), “In 2010, the percentage of people without health insurance, 16.3 percent, was not statistically different from the rate in 2009. The number of uninsured people increased to 49.9 million in 2010 from 49.0 million in 2009” (p. 23). For children, findings from the US Census (2010), indicated, “The uninsured rates were 6.9 percent for non-Hispanic White children, 11.0 percent for Black children, 8.9 percent for Asian children, and 16.3 percent for Hispanic children. These 2010 uninsured rates were not statistically different from the respective rates in 2009” (p. 28). The … uninsured are more than not poor with meager income levels (ASPE Underinsured, 2005).

Ledford, Lambrew, Rothman, and Podesta (2008) posited,

> One of the greatest challenges for an improved health care system is to achieve racial and economic equity. Research demonstrates that socioeconomic status and race or ethnicity often determine the type of care one will receive. Care itself is often of poorer quality for low-income Americans and people of color than that received by populations

> who are white, have more income, or have more education. Low-income Americans, for example, are more apt to receive less timely and effective care due to an inability to pay, and Black Americans, though less likely to have cardiovascular disease, are more likely to die from it. (p. 5)

The Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care developed by Gomes and McGuire (2001; see Figure5) is representative of a lens of health disparities reflective of the health care system, the legal and regulatory climate, discriminatory practices inclusive of stereotyping, bias, and clinical uncertainty of providers of care (LaVeist, 2005). Some scholars would argue that not all dissimilarities of care are representative of disparities (LaVeist, 2005).



SOURCE: Gomes and McGuire, 2001.

Figure 5. Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care.

The Long Range Effects of a Major Crisis in the American Health Care System

While crisis states are often short-lived, given the immediacy of situational support systems (Townsend, 2010), problems in the health care system have prevailed for centuries. To further elucidate, the constructs of Crisis Theory provides a foundational premise for the exploration of social science and healthcare literature. Theoretical concepts relative to health care theories provide useful rhetoric and a lens to view societal alterations, given the intersection of complex and multiple variables. As the nuances are unfolded when a major crisis occurs, according to Crisis Theory, it is paramount to understand the intricacies of the desperation and devastation which inflicts the human body, mind, soul and spirit, and changes which occur as an assumed manner of being is altered by those victims so impacted. The overall healthy outcome of a crisis is for the individual or community to achieve a higher level of functioning or at least be restored to the precrisis level of adaptation (Townsend, 2010).

In an effort to stabilize victims when in a crisis state, as interventions are offered, trust has to be established from the provider of care to the victim and with an offering of hope to stabilize and enhance the healing process with a hopeful outcome of a healthy quality of life, with crisis resolution. According to Erickson (1963), conceptualization of the personality and social processes of man’s eight stages of the life cycle, it is necessary to see the influence on personality development from birth to death and the impact on the individual, the community and society. Successful mastery of maturational milestones has to occur, in each developmental stage— if not a developmental/maturational crisis exists. Maturational crisis during the eight stages of man posited by Erikson could occur anytime developmental milestones are not met.

Trust vs. Mistrust encompasses the first developmental stage which begins with the neonate and continues through infancy. Hope and drive are the virtues during this stage. Erikson (1982) postulated that the development of hope or hopelessness takes place in early childhood. If the child's emotional needs are met, affective states of goodness and hope emerge. However, if the child's emotional needs are not met, hopelessness occurs. The development of trust is the major developmental task. It is essential that primary care providers bond with and provide nurturance and are accessible, responding to the needs of the infant, promoting healthy growth and development, and meeting basic needs required for survival. When the basic needs of the infant are not met, mistrust occurs, altering the virtues of hope and drive. When mistrust occurs, hopelessness and apathy result in traumatic alterations and can lead to lifelong problems associated with mistrust, with a failure to integrate with acceptable societal mores and norms. A positive self-concept, self-image and a healthy personality emerge if trust is mastered in this stage (Antai-Otong, 2003; Bowlby, 1969; Kneisl & Trignoboff; Townsend, 2011). However, if the providers of care exhibit a non-caring attitude, a lack of viable needs associated with SES (i.e. health, education, economics, safety) and impaired family interactions, mistrust occurs, altering hope and drive. Maladaptive behaviors can influence healthy growth and development likely to occur from the infant as transitioning occurs through other stages of the developmental life span, which impacts the progressive growth of future generations. Human, social and economic capital can be severely compromised exhibiting a lack of community cohesion, scarce economic goods, and low levels of social integration. A lack of social goods directly impacts, economic, social and human capital in negative contexts. Induced states of anomie can negatively impact actualization of potential. Sadana and Harper (2011) conveyed,

> A child requires nurturant conditions to thrive. Environments from the intimate realm (e.g. family and community) to the distal (e.g. national and global contexts), interact with biological characteristics to determine a young child's developmental trajectories in the physical, language/cognitive, and social/emotional domains. Inequities in child development result from inequities in access to nurturant environments. Further, inequities that manifest in the earliest years persevere, resulting in inequities in health and human development throughout the lifespan; early nurturant conditions are critical for well-being. (p. 133)

One's socioeconomic position encompasses many variables inclusive of: (a) income, (b) quality of early life, (c) education, (d) employment and career opportunities, (e) adequate nutrition, (f) quality housing, (g) social supports, (h) experiences of social exclusion, and (i) experiences of unemployment and employment insecurity across the life span. These referenced areas align with social determinants of health (Rafael, 2004, 2006).

The significance and impact of SES from the birth of neonate throughout the lifespan serve as independent predictors of the development and demise of individuals from chronic health diseases which impacts health status. Chronic health conditions are influenced by SES and are inclusive of: (a) diabetes, (b) disorders of the respiratory system, (c) heart disease and some cancers and other health conditions (Raphael 2006; Smith, 2003). Structural and institutionalized barriers intersect with behavior which ascribes to cultural fallout and directly correlates with strain theory (Merton, 1938). According to the conceptualization of Travis Hirschi's (1969) social bond theory, delinquent behavior is most likely to persist when youth have fragile connections to family, school and community. In essence, social structure is definitely impacted with behaviors that are maladaptive. Human potential has a risk of not being actualized (Galtung 1969). The lack of actualization of human potential relates to structural violence as posited by Johan Galtung (1965). Strain theory correlates with anomie as conceptualized by Merton.

The significance of a health care system, in a state of crisis, which fails to meet the needs of its constituents, has far reaching ramifications, evoking a manacle of disparities. The lack of equitable social goods contributes to societal decay. Trust cannot occur in a healthcare system which does not meet the needs of all of the constituents it seeks to serve in a democratic society, mistrust occurs when the needs are not met, hopelessness, and despair are long lasting, leading to a poor quality of life, correlating directly with Erickson's first stage of the developmental life span.

The crisis of healthcare in the 21st century aligns to a history of specificity uniquely pertinent to the care received by Black Americans from their existence and unsought presence in the land of liberty. Byrd and Clayton (2002) posited,

> Some characteristics of this African American health crisis include persistent segregation of the health system along race and class lines, race-and class-based inequities and inequalities endemic to each structural component of the health system the origin of which is over 375 years old; significant race and class based health outcome and health status disparities—many of which are worsening, and an African American health insurance crisis wherein 25 percent of African Americans are uninsured, at least 25 percent depend solely on stigmatized and inferior government insurance(Medicaid or public aid) for basic health services. This contrasts with 12.4 percent of White Americans uninsured, with estimates of another 15 percent underinsured and 6.8 percent covered by Medicaid. (p. xxx)

Socioeconomics and the Intersections of Health and Education

A review of the literature indicated that there is a positive association between health and socioeconomic status (SES), whether measured by education, occupation, or income, is largely due to the effects of SES on health, not vice versa, and downward mobility among persons in poor health cannot explain the association (Doornbos & Kromhout 1990; Fox, Goldblatt, & Jones, 1985; Power, Manor, & Fogelman, 1990; Wilkinson, 1986, p.720). Social class according to most social scientists is used synonymously with socioeconomic status and is akin to race as an abstract concept. The variable of occupation is difficult to “operationalize”. Occupation as a nominal concept does not evoke agreement with all social scientists. In essence, there exists no stable and reliable scale that connotes a consensus of agreement with a nominal value. Occupation when explored is often discussed in terms of prestige; no fixed indicator is addressed over prestige of one’s occupation over another (Bundrys, 2010).

Winkleby, Jatulis, Frank and Fortmann (1992) surmised,

> One of the strongest and most consistent predictors of a person’s morbidity and mortality experiences is that person’s socioeconomic status. This finding persists across all diseases with few exceptions, continues throughout the entire life span and extends across numerous risk factors for diseases. (p. 816)

Winkleby, et al. (1992) asserted the significance of the impact of SES on disease substantiates the vital importance of its measurement, given the complexity of the concept and the associated and broad variables. Conceptualization of SES often occurs in combination with influences associated with occupational, financial and educational dimensions. In discussion the interrelationships of the afore-referenced dimensions, it is necessary to reflect upon the differences associated with individual and societal forces and their relevance to disease and health. Winkleby, et al. (1992) related the following regarding each dimension: (a) “income reflects spending power, housing, diet, and medical care; (b)occupation measures prestige, responsibility, physical activity, and work exposures; and (c) education indicates skills requisite for acquiring positive social, psychological, and economic resources. While some researchers suggest a variation in the dimensions relative to predictability and influence on health, a consensus of the literature indicates that these variables intersect and influence healthcare outcomes. Education as an indicator of social status allows more stability, providing its own measure, once acquired, education does not drop. A cursory review of social science and healthcare literature revealed that educational attainment is a powerful indicator of overall health status (Bundrys, 2010). Governmental data, according to Bundrys (2010), recognized educational attainment occurs in juxtaposition with mortality statistics. A review of health care literature noted most discussions and more complete statistical analyses reveal findings relative to two main social groups, Black and White; however, disparities impact other minority social groups.

The intersection of race and poverty impacts ones agency, “economic inequality directly affects poor people as more of a society’s resources get shifted to the well-off” (Bundrys, 2010, p. 398). More significantly, a greater percentage of Blacks than Whites are considered poor. Additionally, poverty has consequences in terms of performance in school, use of the health care system, and quality of attained employment (p. 398). “No examination of the health effects of poverty can ignore the relationship between economic inequality and poverty. Societies that are economically unequal have higher levels of poverty” (Bundrys, 2010, p. 398).

The Construction of Race and Healthcare

Wright and Rogers (2010) posited,

> Race and racial inequality have powerfully shaped American history from its beginnings. Americans like to think of the founding of the American colonies and, later, the United States, as driven by the quest for freedom – initially, religious liberty and later political and economic liberty. Yet, from the start, American society was equally founded on brutal forms of domination, inequality and oppression which involved the absolute denial of freedom for slaves. This is one of the great paradoxes of American history – how could the ideals of equality and freedom coexist with slavery? We live with the ramifications of that paradox even today. (p. 1)

In the United States of America, the poor, certain racial and ethnic minorities, most conspicuously Black Americans may encounter a day-to-day existence of deprivation and basic necessities associated with marginality, relegated to a meager existence in the social hierarchy. Social location and social goods are compromised and often not accessible. Agency can be compromised with a sense of struggle to a most humble form of existence or being. "*Becoming"* and actualization of potential can be altered by structural inequities. People of color, respectively Black Americans whose lived experiences encompass a history of chattel slavery, could possibly encounter racial discrimination in day-to-day interactions given the fundamental premise of the cultural ethos of racial discrimination in the United States through overt and covert prejudicial and discriminatory acts, given structural arrangements in a capitalist society (Takaki, 2000).

"A central idea articulated by many race scholars in the social sciences and legal literature is that race is a central organizing principle within and across societies" (Peterson &

Krivo, 2009, p.905). Founded upon a system which favored the institutionalization of racial slavery, and the dynamics associated with White privilege, supremacy and superiority of the dominant race, a history of racism and discrimination against people of color is deeply woven and ingrained in the fabric of social life in American society. When race is constructed from a social perspective, advantages are organized from the dominant group affords social privileges (i.e. supremacy, whiteness as property) to majority social group members. The social construction of race is representative of a continued structure of oppression to minority group members and intersects with historical hegemonic institutions (i.e. systemic, institutional and systematic) which encompasses political, cultural, economic, and educational venues, which profoundly limits the agency of people of color (i.e. Hispanics and Black Americans).

The DHHS (2001) further acknowledged,

> Race is not a biological category, but it does have meaning as a social category. Different cultures classify people into racial groups according to a set of characteristics that are *socially* significant. The concept of race is especially potent when certain social groups are separated, treated as inferior or superior, and given differential access to power and other valued resources. (p. 9)

Allen (2005) conveyed, “Racial hierarchy is not merely a part of this nation’s distant painful past—it is also a fact of the present and prologue to our future” (p. 18). The dominance of a racial hierarchy presents systemic, institutional and systematic structures in the day to day lived experiences of those who are marginalized and disenfranchised. The social groups impacted so adversely include members in the lower rank of the hierarchy, those with deeper melanotic pigment which includes Black Americans. Most often scholars on race in the 21st century align to the hierarchal theory of racial positioning. However, Myrdal (1944) in aligned to the caste system theory of racial distinction. The caste system provided a means to justify inferiority in varied contextual differences of the dominant group in regards to the Negro. Myrdal (1944) purported,

> The dominant interest in rationalizing and defending the caste system can be specified in the demand that the following statements shall be held true: (1) The Negro people belong to a separate race of mankind. (2) The Negro *race* has an entirely different ancestry. (3) The Negro race is inferior in as many capacities as possible. (4) The Negro race has a place in the biological hierarchy somewhere between the white man and the anthropoids. (5) The Negro race is so different both in ancestry and in characteristics that all white peoples in America, in contradistinction to the Negroes, can be considered a homogeneous race. (6) The individuals in the Negro race are comparatively similar to one another and, in any case, all of them are definitely more akin to one another than to any white man. (pp. 103–104)

The construction of race varies according to scholars. The 1950 United Nations Educational, Scientific and Cultural Organization (UNESCO) statement on race conveyed,

> The biological fact of race and the myth of 'race' should be distinguished. For all practical social purposes 'race' is not so much a biological phenomenon as a social myth. The myth of 'race' has created an enormous amount of human and social damage.(Para 14)

Omi and Winant (1994) posited race is a socio-historical concept; the meaning and expression are concretely defined by historical contexts and specific social relations. Race from a social concept is a variable, shaped by social societal forces. Omi and Winant (1994) define racial formation as, "the sociohistorical process by which racial categories are created, inhabited, transformed, and destroyed" (p. 55). Thereby, a rejection of the biologistic notions of race is rejected in the social sciences. The expressions of racialized meanings from social relations and certain epochal periods, provides significance to the social science concept of racial theory. Through this conceptualization, the categories and meaning of race can be contested in actions which are collective and personal. Racial categories can be destroyed, reformed and transformed in given time periods. Racial formation is the term used by Omi and Winant (1994) to encompass the processes and content of social, political and economic forces which are shaped by the formation of racial meanings and categories with race assuming a central position or central axis of social relations. Omni and Winant stated, "The effort must be made to understand race as an unstable and "decentered" complex of social meanings constantly being transformed by political struggle" (p. 9). Race from a "decentered" complex extends beyond "boundaries of skin color, super-exploitation, social stratification, discrimination and prejudice, cultural domination and cultural resistance, state policy", race is relative and exists in some measure "in every identity, institution and social practice in the United States" (Rothenberg, 2007, p. 19). Race cannot be seen as a mere illusion as color blind racism tenets reflective of this construction of racial theory (Rothenberg, 2007). "The idea of race and its persistence as a social category ~~is~~ only given meaning in a social order structured by forms of inequality—economic, political, and cultural—that are organized, to a significant degree, by race" (Omi, 2001, p. 254).

A Historical Review of Race

According to Smedley and Smedley (2005), in a historical review of race a conceptualization of the term was embraced as a folk idea between the 16th and 18th centuries categorized in terminology associated with: (a) species, (b) kind, (c) sort, (d) breed, and (e) type. However, closer to the end of the 17th century, a gradual change in conceptualization occurred in terminology with those interfacing with North America inclusive of Native Americans (Indians), Europeans and Africans. Early in the 18th century, race as a term increased in usage in written form and records and became more standardized and uniform. Wide usage of the term occurred during the Revolutionary era solidifying its meaning to social categories of Whites, Indians and Blacks, thereby recognizing a structure and ideology that had not previously existed. Smedley and Smedley (2005) confirmed, "The fabrication of a new type of categorization for humanity was needed because the leaders of the American colonies at the turn of the 18th century had deliberately selected Africans to be permanent slaves" (p. 19). Given credence to the final ruling of the *Dred Scott Decision*, in March 1857, a paradigmatic belief centered on the status of the Negro as one of inferiority. The decision from the U.S. Supreme Court surmised,

> They had for more than a century before been regarded as beings of an inferior order, and altogether unfit to associate with the white race, either in social or political relations; and so far inferior that they had no rights which the white man was bound to respect, and that the negro might justly and lawfully be reduced to slavery for his benefit. He was bought and sold, and treated as an ordinary article of merchandise and traffic, whenever a profit could be made by it. (The New International Encyclopedia/ Dred Scott Case, 2010, Para I)

Throughout the 19th century rhetoric occurred over the humanity of Africans with paradigms associated with inferiority of this social group over other forms of humanity. The conceptualization of difference relegated the separate creation of Africans, thus, justifying a belief of having less than human status. This acclaimed and perceived non-human status of

Africans served as validation for Christians to position the ownership through slavery and the exploitation of the agency of this social group.

According to Smedley and Smedley (2005), the endurance of the paradigmatic thoughts from 18th and 19th century carried over to the 20th and 21st centuries. Ideologies associated with human difference are critical to the social structure and explicitly impact social policies. In essence, the ethnographic realities embrace ideological tenets of racism and racist behavior, documented and supported by massive amount of diagnostic historical literature in North America (Smedley & Smedley, 2005). Peterson and Krivo (2009) conveyed,

> In the United States, this means that society is patterned in such a way as to reproduce and sustain the privileges of whites over other groups, and to position blacks at the bottom of the social hierarchy. The social positions of other ethnoracial groups are often considered to fall between these two extremes. (p. 905)

The following characteristics associated with racial distinctions are widely documented in both sociological and historical studies: (a) physical markers of biological difference and physical features which are innate and inherited in raced-based societies designation of exclusive groups becoming markers of race status varying from the shape of the eyes, the texture of hair and skin color, (b) a fundamental belief that races are naturally unequal and must be hierarchically ranked (indicative to the U.S. and South Africa), with occupancy of the lowest rung of the hierarchy, by Africans and their descendants (c) distinctive inherited cultural behaviors linked to biology which informs separation of the races, (d) a justification of segregation in intermarriage, cohabitating, intermating and separate spaces and places, assuming that racial differences are unalterable and significant. Racial classifications are stipulated by the social and legal system by law inclusive with markers of physical distinctions inclusive of lip thickness, skin color, width of the nose "(racial identity by law)." (This obtained until recently in the United States and South Africa.). …"It is the culturally invented ideas and beliefs about these differences that constitute the meaning of race" (p. 20).

As immigrants came to the United States, they were ranked lower than Europeans but ranked between Black and White. According to Wright and Rogers (2010),

> Racial *classifications* do not logically imply racial *oppression…* This is how ethnic distinctions are sometimes experienced[.] [For example], to be of Irish or Swedish or Italian descent in America is to share a certain cultural identity, and perhaps to participate in certain cultural practices as well, but this does not imply any forms of oppression involving these categories. (p. 2)

Racial scholarship provides interesting critiques in assessing the nuance of assimilation of non European groups sustaining a position in the pinnacle equal to Northern European Americans. However, according to Smedley and Smedley (2005), "The single most important criterion of status was, and remains, the racial distinction between Black and White" (p. 20). Racial theory varied with perceptual scholarly discourse. Peterson and Krivo, (2009) posited,

> …Bonilla-Silva and Glover have proposed that the racial order is tripartite, with whites at the top of the hierarchy, blacks at the bottom, and a set of others including light-skinned Latinos, Asian Americans, Middle Eastern Americans, and multiracial individuals structurally in the middle as honorary whites. According to this organization, blacks include a broad set of very dark-skinned groups. This perspective suggests growing complexity in the nature of racial stratification in the United States. …scholars appear to agree that the racial order in the United States is heavily defined by

> the extremes of white privilege and black oppression. This perspective suggests growing complexity in the nature of racial stratification in the United States. (p. 905)

Regardless of a groups' specific position, the institutions which encompass the racialized social system are constructed to maintain the hierarchical position of minority oppression and white privilege. Systematic differentiation exists in the health care system, schools, politics and the labor market inhibiting opportunities for people of color, with dominant group commanding greater access to institutional resources. Therefore, disproportionate opportunities to attend better schools, jobs which are prestigious, greater political representation, obtaining a high quality of health care, use of better doctors and hospitals are at the disposal of members at the top of the hierarchy (Peterson & Krivo, 2009). The hierarchical position allows accrual of institutional rewards and resources indicative of wealth, educational attainment, and higher incomes than members positioned at the pinnacle.

Peterson and Krivo (2009) asserted,

> Superior opportunities and rewards take on a life of their own in furthering the privileges of whites. That is, whites' accumulated advantages facilitate their ability to maintain superior positioning throughout society. …access to communities with the best public elementary schools and high schools not only improves access to college, along with all of the opportunities flowing from high educational attainment, but also increases home values, and hence the wealth of residents. Wealth can, in turn, help finance college and other investments that facilitate continued returns. In contrast, non-whites, and particularly blacks, experience significantly lower life chances in institutional arenas. This includes a greater likelihood of poor quality education, low

> prestige jobs with associated low income, and residence in heavily impoverished communities with low home values and weak potential to accumulate wealth. (p. 906)

Smedley and Smedley (2005) gives credence to the expanse of published scholarly property which acknowledge the difference in the quality of health care for racial groups in comparison to dominant tier group members evidencing the depth and consistency over time of the disparity in health consistent with minorities receiving less quality care, in all domains.

These disparities are consistent with SES and in a very few cases, seem to disappear when controlling for SES. However, for most studies, disparities remain even when controlling for SES and other access related factors. Consistency is evident when comparing black patients to European patients and with some evidence of the same with Hispanic to white patients. At this juncture, evidence is not available when comparing Pacific Islander Americans, American Indians/Alaska Natives, and Asian Americans. An overall analysis of health disparities indicate: (a) a lower quality of care for Hispanics and Black Americans for quality clinical services and across a range of disease entities (i.e. diabetes, cardiovascular disease, mental health, HIV/AIDS, cancer, appropriate diagnostic testing, “other infectious and chronic diseases and clinical services), (b) less desirable services are more likely received by black Americans inclusive of amputation of a total limb or alteration to a section of a limb, (c) the existence of disparities in private and public, teaching and non teaching hospitals, (d) a higher mortality of minorities, who fail to receive the same treatment measures than Caucasian counterparts,(i.e. “surgical treatment for small-cell lung carcinoma”(p. 23), and (d) differences in clinical factors inclusive of comorbidities, age, severity and presentation of disease.

Inequitable care to Black Americans is not a new phenomenon, Byrd and Clayton (2001) posited,

> Racism in medicine, a problem with roots over 2,500 years old, is a historical continuum that continuously affects African-American health and the way they receive healthcare. Racism is, at least in part, responsible for the fact African Americans, since arriving as slaves, have had the worst health care, the worst health status, and the worst health outcome of any racial or ethnic group in the U.S. Many famous doctors, philosophers, and scientists of each historical era were involved in creating and perpetuating racial inferiority mythology and stereotypes. Such theories were routinely taught in U.S. medical schools in the 18th, 19th, and first half of the 20th centuries. The conceptualization of race moved from the biological to the sociological sphere with the march of science. The atmosphere created by racial inferiority theories and stereotypes, 246 years of black chattel slavery, along with biased educational processes, almost inevitably led to medical and scientific abuse, unethical experimentation, and overutilization of African-Americans as subjects for teaching and training purposes. (p. 11S)

Racism has a significant and profound impact on health and behavior. Shariff-Marco, Klassen, and Bowie (2010) postulated,

> … general racism was associated with smoking, binge drinking, and being overweight or obese; health care racism was associated with not being up to date with screening for prostate cancer…. Associations between general racism and lifestyle behaviors suggest that racism is a potential stressor that may shape cancer-related health behaviors…. (p. 364)

Surviving, buffering and living in a system of institutional, systemic, and structural racism typified by violence can be destructive to gaining a positive quality of life. Randall (2001) postulated,

> … institutional racism is the result of the disparate impact of practices and policies, inadequate laws and regulations and ineffective enforcement of existing laws and regulations, cultural incompetence of health care providers and institutions, and socioeconomic inequities that are disproportionately distributed along racial lines. These factors contribute to racially disadvantaged groups having disparities in health status, unequal access to health care services, insufficient participation in health research or exploitation in health research and insufficient receipt of health care financing. (p. 7)

Supportive contexts can often help to negate the horror experienced when living in a society that offers marginalization as an acceptable existence and the associated status of-second class citizenship, with ranks in the lower rungs of the hierarchy.

Exhibiting a propensity for kindness, hoping for a future that would alter the way of existence, and a quality to life which simulates the “other” is significant to the soul of Black Americans, as was the quest to receive adequate health care for the Negro men in 1932 when the USPHS Tuskegee Untreated Syphilis study began (Thomas & Quinn, 1992)

Violence and its Constructions in the Health Care System

A life diminished of potential unrealized and a lack of actualization due to disparities and inequities in positive health outcomes denotes a form of violence which is structural. The inequities associated with barriers which are structural, impact minorities and the poor. The World Health Organization (WHO) (1995) indicated,

> Poverty wields its destructive influence at every stage of human life, from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all those who suffer from it. (p. 28)

Illness and premature death may lead to suffering which is extreme and insurmountable (Farmer, 1996). The essence of human suffering evokes a cry of despair; one of a grave and unsustainable loss to the human soul and spirit resulting in a sense of misery, stifling growth, diminishing the realization of actualized potential. “Suffering is a universal phenomenon, but the world’s poor are not only subject to more suffering but they are often consigned to suffer in silence” (Farmer, p. 261). The systemic pervasiveness of the disparities which exist in criminal justice, and the educational system for people of color, more particularly so for Black Americans, and Latinos also impacts and exists in the health care system through varied intersections and stratifications. According to the Institute of Medicine (IOM), findings from critical studies, and different eras of time, substantiates the persistence of inequality in the healthcare system. The Philadelphia Negro, Unequal Treatment, An America Dilemma, and the Heckler Report provide concrete empirical findings and the nuances associated with the persistent disparity in the health care system, the inequities which intersect with social determinants of health. Gunnar Myrdal(1944) found, “Area for area, class for class, Negroes cannot get the same advantages in the way of prevention and care of disease that whites can” (as cited in Geiger, 2002, p. 417). According to Gieger as cited in Byrd and Clayton (2002), Mydral stated, “…Discrimination increases Negro sickness and death both directly and indirectly and manifests itself both consciously and unconsciously” (p. xvi).

The Heckler Report also known as the *Report of the Secretary’s Task Force on Black and Minority Health* (1985) found,

> Despite the unprecedented explosion of scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks, Hispanics, Native Americans, and those of Asian/Pacific Islander heritage have not benefited fully or equitably from the fruits of science or from systems responsible for translating and using health sciences technology. (USDHHS, 1985, p. ix)

Heckler (1985) emphasized, "a sad and significant fact; there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with the population as a whole" (p.ix). Further acknowledgement was made to the depth and existence of the disparity which has been experienced by minorities. The USDHHS (1985) stated, "That disparity ever since accurate federal recording keeping began—more than a generation ago (USDHHS, 1985, p. ix).

The violent nature of the disparities identified by the Task Force on Minority Health (1985) revealed that excess deaths were occurring for Black Americans, "For Black males and females combined, excess deaths accounted for 47 percent of the total annual deaths in those 45 years old or less, and for 42 percent of deaths in those aged 70 years or less" (p. 4). Another conceptualization of excess deaths as defined by the CDC (2000) is, "…the difference between the number of deaths observed in a racial/ethnic group and the number of deaths that would have occurred in that group if it had the same death rate as the non-Hispanic white population" (Para II).

A discourse on health disparities and health care disparities would be neither viable nor reasonable without acknowledging social structure, social location, social relationships, social goods and resources and the inequity which continues to exist in modern day America for 'non dominant group members.' Such as the existence of unjust disparities in the criminal justice and educational system, so does the existence of the disparity in the healthcare system, provoke injustices to the disadvantaged.

Social stratification in the United States is based primarily on race with the dominant group maintaining a historical and sustained existence on the pinnacle of the social hierarchy. This hierarchical presence of majority group members' impacts socially disadvantaged groups in domains which encumber socially negative outcomes, which Galtang (1960) surmised as being low on power. Dominance of majority group members is often expressed in discriminatory venues; in essence, in "institutionalizing social relationships of dominance and oppression" (Krieger, 1999, p. 301). Krieger (1999) postulated, discriminatory practices of dominant groups [are used] "to maintain privileges they accrue through subordinating the groups they oppress and ideologies they use to justify these practices, with these ideologies revolving around notions of innate superiority, and inferiority, difference, or deviance" (p. 301).

Braveman and Grushon (2003) further distinguished and clarified the significance of social advantage and the associated variables in the schemata. Braveman and Grushon (2003) indicated,

> *Underlying social advantage or disadvantage* refers to wealth, power, and/or prestige—that is, the attributes that define how people are grouped in social hierarchies. Disadvantage also can be thought of as deprivation, which can be absolute or relative; the concept of human poverty developed by the United Nations Development Program reflects severe disadvantage. Thus, *more and less advantaged social groups* are groups of people defined by differences that place them at different levels in a social hierarchy. Examples of more and less advantaged social groups include socioeconomic groups

> (typically defined by measures of income, economic assets, occupational class, and/or educational level), racial/ethnic or religious groups, or groups defined by gender, geography, age, disability, sexual orientation, and other characteristics relevant to the particular setting. (p. 254)

Health care and health disparities are implicated in the positive agency of the disadvantaged. To fully understand and quantify the significance and impact of health and health care disparities, clarity is necessary to distinguish comparative methodologies, indicators and ratios, although not all of the afore-referenced variables are the direct focus of this study. According to Grushmon (2006),

> … measuring a health disparity requires three basic components: (*a*) an indicator of health or a modifiable determinant of health, such as health care, living conditions, or the policies that shape them; (*b*) an indicator of social position, i.e., a way of categorizing people into different groups (social strata) based on social advantage/disadvantage, such as income, education, ethnic group, or gender; and (*c*) a method for comparing the health (or health determinant) indicator across the different social strata, such as a ratio of the rates of the health indicator in the least and most advantaged strata. (p. 187)

The Social Hierarchy

Health data reported today in the United States most often include categories of: (a) Black/Black Americans, (b) Hispanic/Latino American (Hispanic–an ethnic category), (c) American Indians and Alaskan Natives, (d) Asian Americans and Pacific Islanders, and (e) Whites. While discourse exists regarding the construction of race from social vs. biologistic perspectives, racial groups are still utilized in collecting health data.

Historically, in the United States of America racial and health disparities have evoked biased inequities in health care delivery, quality and access. According to the U.S. Commission on Civil Rights (1999a), "Black Americans experience healthcare differently from [W]hites and other populations within the nation" (p. 23). The IOM listed superfluity of reasons, Black Americans have experienced "the worst health status, suffered the worst health outcomes, and been forced to utilize the worst health services of any racial or ethnic group" (Byrd & Clayton, 2000, p.15).

The Institute of Medicine (IOM) publication in 2002, *Unequal Treatment* substantiated a broad spectrum of disparities in health care. Health care disparities encompass treatment distinction between racial groups. The report found, "Bias and stereotyping by providers significantly and directly contribute to minority disparities" (p. 37). The findings are vast, impacting morbidity and mortality excess death rates, across the lifespan, from birth to death. The systemic relevance of an acerbic societal stance in biomedical health and sociocultural contexts, to a people with a legacy of 2000 years of deficits in vast areas and perceived differentials in intellect, genetics and inferiority, with an existence in chattel slavery of 246 years, encompassing a "slave health deficit and subsystem" depicting 100 years of discrimination and segregation. Black Americans have endured inhumane suffering in broader American society as well as the healthcare market place, with an existence in a "Negro model ghetto", encumbering a historical and contemporaneous oppression, intersecting economic, political and social contexts in a dual and inequitable healthcare system (Byrd & Clayton, 2000).

Farmer (2004) relayed the horror of suffering, in stripping one of a voice of empowerment and rights associated with the philosophic underpinning of living in a democratic society. Farmer (2004) conveyed,

> Knowledge of suffering cannot be conveyed in pure facts and figures, reportings that objectify the suffering of countless persons. The horror of suffering is not only its immensity but the faces of the anonymous victims who have little voice, let alone rights, in history. (p. 40)

Disparities, from a broader perspective in American society, directly impact factors in social and economic contexts, which portray racial and ethnic discrimination in various sectors, including the health care system. "These underlying causes are complex, often reflecting systematic, social, political, historical, economic and environmental factors that accumulate across people's lifetimes and are transferred across generation" (Sadana & Harper, 2011, p. 8). The Institute of Medicine (Smedley, Stith & Nelson 2003), confirmed, "Racial and ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention" (p. 3).

An overwhelming body of knowledge on health care literature and research studies found that Black Americans share a quality of health substantially less than Northern European American counterparts. Persistent and pervasive gaps in health care continue to render demise, persistent demise, attacking Black Americans at insurmountable rates of death compared to Northern European American counterparts. While the entire Black American community is impacted from birth to death with deficits of social goods and a lack of empowerment, intersecting with parsimonious health equity and quality, the Black male is targeted at an alarming rate.

The National Center on Minority Health and Health Disparities(2002) denoted health disparities as diseases, disorders, and conditions that disproportionately afflict individuals who are members of racial, ethnic minority, underserved, and other vulnerable groups. Health disparities continue with chiasmic differences for people of color in comparison to dominant group members.

At no time in the history of the United States has the health status of minority populations—Black Americans, Native Americans and, more recently, Hispanics, and several Asian subgroups—equaled or even approximated that of White Americans. The health of all American racial ethnic groups has improved dramatically, particularly over the last six decades, but the paired burdens of excess morbidity and decreased life expectancy for people of color have been noted over several centuries and have proved, even recently, to be stubbornly resistant to substantial change (Byrd & Clayton, 2000; National Center for Health Statistics, 1998). According to the Institute of Medicine (2003),

> Racial and ethnic disparities in healthcare emerge from an historic context in which healthcare has been differentially allocated on the basis of social class, race and ethnicity. Unfortunately, despite public laws and sentiment to the contrary, vestiges of this history remain and negatively affect the current context of health care delivery. (p. 123)

The National Center for Health Statistics (NCHS; 2002) conveyed the life expectancy for Whites in 1999 were 6 years greater in length than Black counterparts. These data are indicated with a life expectancy of 77 years. With the stated life expectancy, illness and death is increased in practically every area in comparison to physical health, equating an increased mortality rate for Black Americans over Northern European American counterparts.

According to the IOM study Unequal Treatment (2003), “In 1995, the overall African-American mortality rate was 60 percent higher than that of whites—precisely what it had been in 1950” (p. 417). In 1994 for every 100,000 males born in the United States, 5,400 Black males lived to the age of 45 years with less than 16,000 surviving to the age of 65 years. In 1991, the death rate for Black males was 660,000 (National Center for Health Statistics [NCHS]). In comparison, Black females, in 1999 population rates of 100,000, 94,000 survived to the age of 45 years in comparison to Northern European female counterparts of 97,000. These data account for a life span of 65 years.

From a public health perspective, a perception is the foremost determinate of a population’s health and the principal explanations for disparities of population groups is derived from hegemonic influences of social, physical and economic spaces, which constitute dominant societal norms and social systems of stratification (IOM, 2003; King, 1996; Menefee, 1996). Of the many variables relative to health care disparities, consistencies are comparable to socioeconomic status (i.e. lack of education, unemployment and income), hazards associated with environmental hazards (inferior housing), occupational inequities, inadequate nutrition, risks which impact lifestyles and behaviors, and vastly different cultural approaches concerning illness and health.

Access to health care, particularly the lack of insurance whether public or private, which continues to persist since the beginning and/or expansion of federal programs such as Medicaid and Medicare (Blendon et al., 1989; IOM 2004; Weinick, Zuvekas, & Cohen, 2000). The American Medical Association (AMA) in 1990, conceded to the reality of the disparity which exists in health care. While recognizing and acknowledging the significance of: (a) sociocultural environmental contexts, (b) socioeconomic status, (c) the restrictions of studies in disparity scholarship, and (d) clinician bias; the AMA emphatically acknowledged, "Disparities in treatment decisions may reflect the existence of subconscious bias.... The health care system, like all other elements of society, has not fully eradicated this [racial] prejudice" (Council on Ethical and Judicial Affairs, 1990, p. 2346). The Sullivan Commission (2004) conveyed the need to resolve the long term issues of inequities in healthcare in varied domains. The Sullivan Commission (2004) stated,

> National efforts to eliminate racial and ethnic health disparities by 2010 and increase the number of underrepresented minority health care providers necessitates a fundamental shift in awareness, attitudes and values as well as systematic examination and reform of institutional structures that sustain persistent patters of unequal treatment and exclusion. (p. 43)

The Sullivan Commission, which was formed to explore the variables relative to health care providers – *Missing Persons: Minorities in the Professions* noted the relevance of the structural nature of the disparity associated with health outcomes. The Sullivan Commission (2004) posited, "Racism is not limited to expression to individuals, but can also be a system of structures, ideologies, policies, practices, and customs that generate or perpetuate unduly disparate patters of exclusion and unequal treatment based on race or ethnicity" (p. 40). Findings study revealed that racism in the health care system exists and can be expressed in the following contexts: (a) lack of shared governance or power which is institutional, controlled by one group, (b) control of resources and opportunities, albeit education, practice, training, favoring a particular group (racial/ethnic), (c) lack of parity in faculty appointments, administration and research opportunities, favoring a particular group, and (d) imposition of ethnocentric culture by schools of health profession and institutions which provide health care.

The Sullivan Commission (2004) confirmed that the afore-referenced circumstances are not always intentional but can be unintentional occurring by acts of omission and commission. The Sullivan Commission (2004) surmised the social phenomenon of racism can be analyzed and understood on three levels: (a) institutional, (b) internalized, and (c) personally mediated. The Commission clarified that the afore-referenced areas don't defy the occurrence of racism in the health care system, nor is the impact neutralized or eliminated by the social construction of race as an ideology. Racism internalized provokes a deleterious impact on those who are so stigmatized in overall self-value and worth, directly impacting self-esteem and self-devaluation of potentialities and endowment in intellect.

The Sullivan Commission (2004) surmised, "There are many historical hurdles to overcome. The ghosts of segregation and discrimination, inside and outside the health professions, still influence the quality of, and the access to, and education in the health professions for minorities" (p. 39). The Sullivan Commission (2004) expressed a critical need for racially concordant providers for minority populations, with an implicit need to educate and retain minorities for occupations in the health care professions.

In healthcare, theorists such as Kubler-Ross, Maslow, Selye, Erickson typically construct models which flow along timelines and hierarchies. Astoundingly, these parallel the constructs of the social theorists (Galtung, Gil, Farmer, Weber, Calhoun, Dubois, Bell, Fanon, Marx, Ford, Airhihenbuwa and others). Given Abraham Maslow's (1954) hierarchy of needs categorized as humanistic theory, higher order needs such as self-actualization cannot be fulfilled until lower order needs are met; from a hierarchal perspective and structure, the lower four order needs in the hierarchy are deficiency needs, and have to be fulfilled for mere survival and existence. The hierarchic needs theory is represented as a pyramid (see Figure 5), which typifies the order that is basic to a healthy existence. Lower level needs are transcended by higher levels of needs with the pinnacle of the hierarchy representative of self-actualization. Negative societal stagnancies can prevent individuals and subcultures from moving up the hierarchy. When basic needs are not met which can result as alterations in the social contract, members of society can become poverty stricken environments, negotiating for the basic liberties assumed with living in a democratic society (i.e. lack of food, clothing, healthcare, education and safety) due to structural boundaries—violence is rampant, which is reflective of the barriers in healthcare, more specifically, social determinants, the criminal justice system and education.

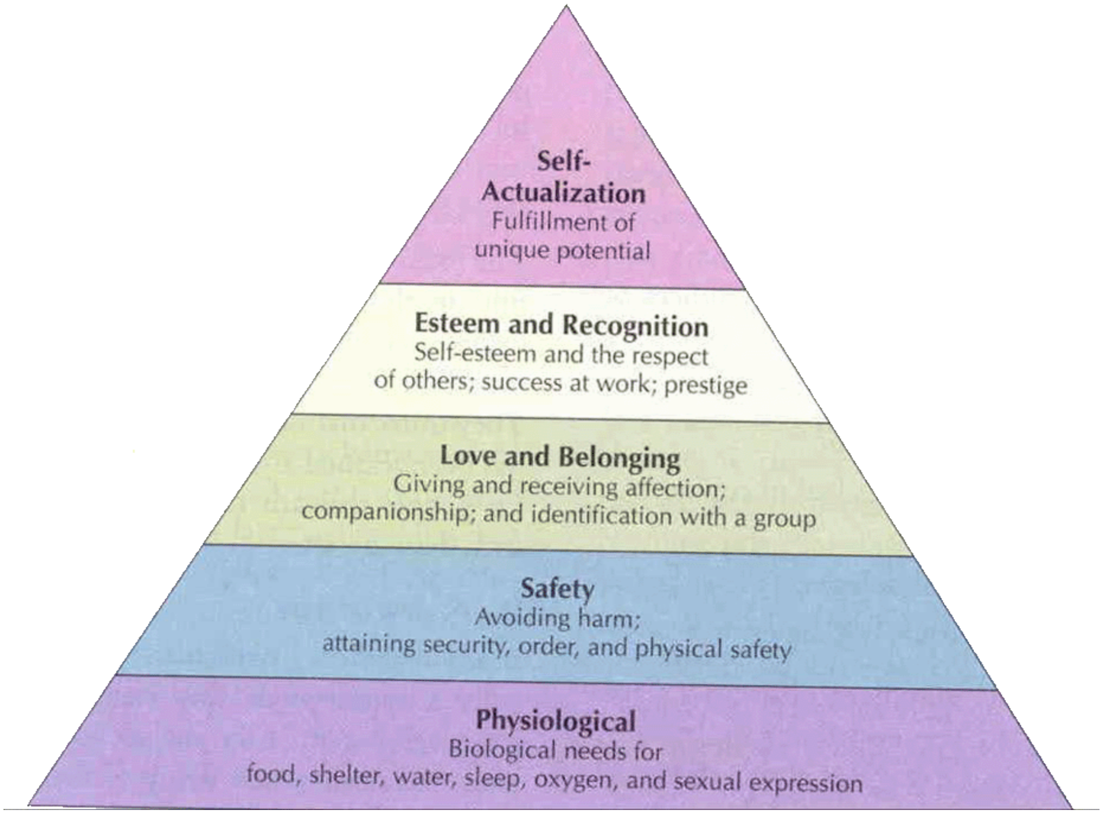


Figure 5 Maslow's Hierarchy of Needs

The Southern Black Belt, a Barren Land

While the setting for this study is limited to counties in the southeastern district in the state of Alabama, the Black Belt is a collection of rural counties which follows the coastal plain in a crescent shape extending into the Mississippi Delta (see Figure 6). In totality, the Black Belt counties comprise 623 counties. Counties central to this study include counties in the expanded Black Belt area in the state of Alabama; most commonly called Black Belt Alabama or Black Belt south with a focus on, Macon County, the site of the sentinel event. The Black Belt Counties in totality include Barbour, Bullock, Choctaw, Crenshaw, Dallas, Greene, Hale, Lowndes, Macon, Marengo, Montgomery, Perry, Pickens, Pike, Russell, Sumter, and Wilcox (see Figure 6). When extending the Black Belt region further south the region includes Clarke, Conecuh, Escambia, Monroe, and Washington Counties. However, there appears to be some discrepancy in the literature relative to the determination of the criteria for classification of a Black Belt County. Montgomery County, though more urban than rural is determined by some scholars to lack criteria for this designation. Bliss et al. (1993) stated, “Urban counties in Alabama’s Black Belt (e.g. Montgomery, site of the state’s capital) are sufficiently different from rural counties in terms of economic diversification and other characteristics to warrant their exclusion from this analysis” (p. 221).

Figure 6. Traditional Counties of the Alabama Black Belt

According to Tullos (2004), "Following the forced removal of Native Americans, the Black Belt emerged as the core of a rapidly expanding plantation area" (Para I). Cleland (1920) stated,

> To speak of the 'Old South' is at once to suggest a very definite type of civilization. There has been no more distinctive human product of American soil than the culture of

> the ‘Cotton Kingdom’ of antebellum days. Two generations from the declaration of democratic faith saw flourishing a caste system, rooted in the institution of slavery of which the spread was largely conditioned by geographic factors—the fertile soils and warm temperate climate of the South. (p. 375)

Tullos (2004) further clarified, “Half of Alabama’s enslaved population was concentrated within ten Black Belt counties where the exploitation of their labor made this one of the richest regions in the antebellum United States” (Para. 2). In 1920, a contrast of the two “races” are typified. Tullos (2004), in referencing Booker T. Washington in 1901 in further critiquing the Black Belt indicated,

> A second meaning of Black Belt as a region or place with majority-black population grew as a consequence of the expansion of slavery throughout the southern states. I have often been asked to define the term ‘Black Belt, commented Booker T. Washington. (Para 5)

Washington further clarified in 1901, according to Tullos (2004),

> So far as I can learn, the term was first used to designate a part of the country which was distinguished by the colour of the soil. The part of the country possessing this thick, dark, and naturally rich soil was, of course, the part of the South where the slaves were most profitable, and consequently they were taken there in the largest numbers. Later, and especially since the war, the term seems to be used wholly in a political sense—that is, to designate the counties where the black people outnumber the white. (Tullos, Para 4)

According to Tullos (2004), in a resolution in 1928 by the Communist Party, characterization of the Black Belt Black was described,

> The bulk of the Negro population (86%) live in the Southern states; of this number 74 percent live in the rural districts and are dependant almost exclusively upon agriculture for a livelihood. Approximately one-half of these rural dwellers live in the so-called 'Black Belt', in which they constitute more than 50 percent of the entire population. The great mass of the Negro agrarian population are subject to the most ruthless exploitation and persecution of a semi-slave character. In addition to the ordinary forms of capitalist exploitation, American imperialism utilizes every possible form of slave exploitation (peonage, sharecropping, landlord supervision of crops and marketing, etc.) for the purpose of extracting super-profits. On the basis of these slave remnants, there has grown up a superstructure of social and political inequality that expresses itself in lynching, segregation, Jim Crowism, etc. (p. 6)

Phillips (1905) further clarified the positional role and use of Black Americans in the Black Belt south prior to Reconstruction, "Finally the negroes were discovered to be cheap and useful laborers for domestic service and plantation work" (p. 258). Cleland (1920) stated,

> It was a short-lived civilization this, with its social ideals expressed in the ownership of 'a mansion, a cotton plantation, and a hundred slaves,' but its relics still remain. If one would see them before they are swept away by the hand of progress let him for choice go to Alabama and in Alabama to the Black Belt. Ask almost any Alabaman where the best ante bellum architecture of the state is to be found and the answer will surely be, 'In the Black Belt.' Ask in what part of the State the people are most cultured and most highly educated, where the traditions and prejudices of the Old South are strongest, and it will be, 'In the Black Belt.' (p. 375)

While physical ownership of slaves is legally outlawed, paradigmatic and hegemonic ideologies remain entrenched of the historical intent and purpose relegated to enslavement. According to Bliss, Howze, Teeter, and Bailey (1993),

> Many constraints are deeply rooted in the social and political history of this region. After the Civil War, material, conditions of life for freed slaves were little changed. Most of the land continued to be controlled by relatively few families, who used share tenancy relationships to maintain the necessary labor force for cotton production. (p. 222)

The Black Belt counties share commonalties inclusive of: (a) dark black loamy soil underlain by red clay,(b) housing stock which is substandard, (c) limited access to health care, (d) low and substandard educational attainment, (e) high rates of unemployment, (f) a proportionally large African American citizenry, and (g) little industrial development or commercial development with an agricultural base. Once denoted prime areas for farming with deep black soil, the lands now are often barren. Gibson (1941) described the condition and changes in the Black Belt in the early twentieth century,

> The Black Belt of today reflects a past more renowned than its present, and much of its individuality represents a heritage of better days…. An agrarian economy rooted in scattered, rolling tracts of prairie soils of unusual pristine richness gave distinction to early society. Slave labor yielded profits to a sparse white population. In early post-slavery decades, a tenant system supplanting the older order perpetuated the prestige of the cotton planter. More recently, soil deterioration, the decline of the cotton crop, and the exodus of many farmers, both white and negro, have resulted in economic and cultural decline. (pp. 1–3)

These collective southeastern rural counties with a higher proportion of African American citizens than the national average, is laden with a history of structural inequities. The people who reside in the crescent shaped Black Belt have a poorer quality of life. In comparison to other regions in the United States, the Black Belt has numerous problems and is often considered the under belly of America. Low educational attainment, socioeconomic status, and home ownership with high poverty and unemployment rates are typical for this area and account for the social disadvantage which exists (Falk, Talley, & Rankin 1993; Wimberley 2008; Wimberley & Morris 1996; Tomaskovic-Devey & Roscigno 1996: Zekeri, 1996). Early mortality prevents potentialities from being actualized. The mortality and health patterns of Black Belt citizens may parallel with the low socioeconomic conditions of the area. Research shows that poor and inadequate health care and a shortened life span align and interrelate with the paucity of socioeconomic conditions of the Black Belt region (Klomegah 2008; Lu, Samuels & Wilson 2004; McLaughlin & Stokes 2002; Oliver & Muntaner 2005; Raphael 2006; Sudano & Baker 2006; Wimberly 2008).

Sadana and Harper (2011) postulated,

> …exposures to material deprivation and economic inequalities, such as poverty and low income, poor nutrition and bad housing, are closely related to employment conditions. These factors may have an important effect on chronic diseases and mental health via several psychosocial factors, life-style behaviours, and stress-induced physiological changes. (p.169)

Health care reform has the potential to impact the citizens of the Black Belt counties in incremental and substantial areas. Models of care which embrace a culturally sensitive approach to health care could increase hope and trust in the health care system and perhaps alter longevity and quality of life. However, the State of Alabama, under the leadership of Honorable Robert Bentley, has failed to accept full provision of *The Patient Protection and Affordable Care Act.* Interestingly, the number of uninsured residents in the state equals, 720,000 which approximates to 15.4 percent (The Associated Press, 2012). Nationally, "minorities comprise 52 percent of the uninsured and suffer from illness and death at a greater rate than Whites" (p. iii).

The Social Determinants of Health

The World Health Organization affirmed, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 1946, p. 2). The WHO (2008), postulated [that] unfair distribution of health outcomes … are growing between the rich and poor, the privileged and marginalized…" (p. 8). The relationship between socioeconomic standing and health is on a continuous gradient at all income levels rather than a gap simply between the rich and poor. This phenomenon occurs whether health differences are measured by income, employment, education, or other markers of social stratification. The greater the differences in health between social groups within a society the steeper the gradient or the greater the inequity (WHO, 2008).

Marmot (2005) stated, "Social conditions powerfully influence both the onset and response to treatment of the major infectious diseases that kill" (p. 1102). In essence, health care is a social determinant in so far as it is influenced by social policies.… (Braveman & Grushmon, p. 254). According to Grant Makers in Health (2010),

> In its 2008 final report, the WHO Commission defined the social determinants of health as the structural determinants and conditions of daily life that create health inequalities,

> such as the distribution of power, income, goods and services, access to health care, schools and education, as well as conditions of work, leisure, housing, and the environment. From the social determinants perspective, clinical care is a minor influence on health relative to social, economic, and individual factors. (p. 1)

Social advantage or disadvantage can influence the quality of the health care received, impacting social determinants and the interrelationship and influence on health outcomes impacting quality of life (see Figure 7).

Braveman and Gruskin (2003) asserted,

> … equity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage. (p. 254)

Numerous studies … conclude that most of these differences in health across different social groups are inequities: they are not due to biologic or genetic factors, but to social factors that are unjust and amenable to policy (WHO, 2008, p. 8).

Social determinants of health, according to Satcher (2011), in the context of the participants of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male were inclusive of: (a) being poor literate share croppers, (b) limited access to healthcare, (c) being born, living, working and residing in the rural south. Satcher (2011) stated, “These conditions had a direct impact on their attitudes, daily lives and health outcomes" (p. 42). According to the Commission on Social Determinants of Health (2008), "Low living standards are a powerful determinant of health inequity" (p. 15).

According to Grushmon (2006)

> … measuring a health disparity requires three basic components: (*a*) an indicator of health or a modifiable determinant of health, such as health care, living conditions, or the policies that shape them; (*b*) an indicator of social position, i.e., a way of categorizing people into different groups (social strata) based on social advantage/disadvantage, such as income, education, ethnic group, or gender; and (*c*) a method for comparing the health (or health determinant) indicator across the different social strata, such as a ratio of the rates of the health indicator in the least and most advantaged strata. (p. 187)

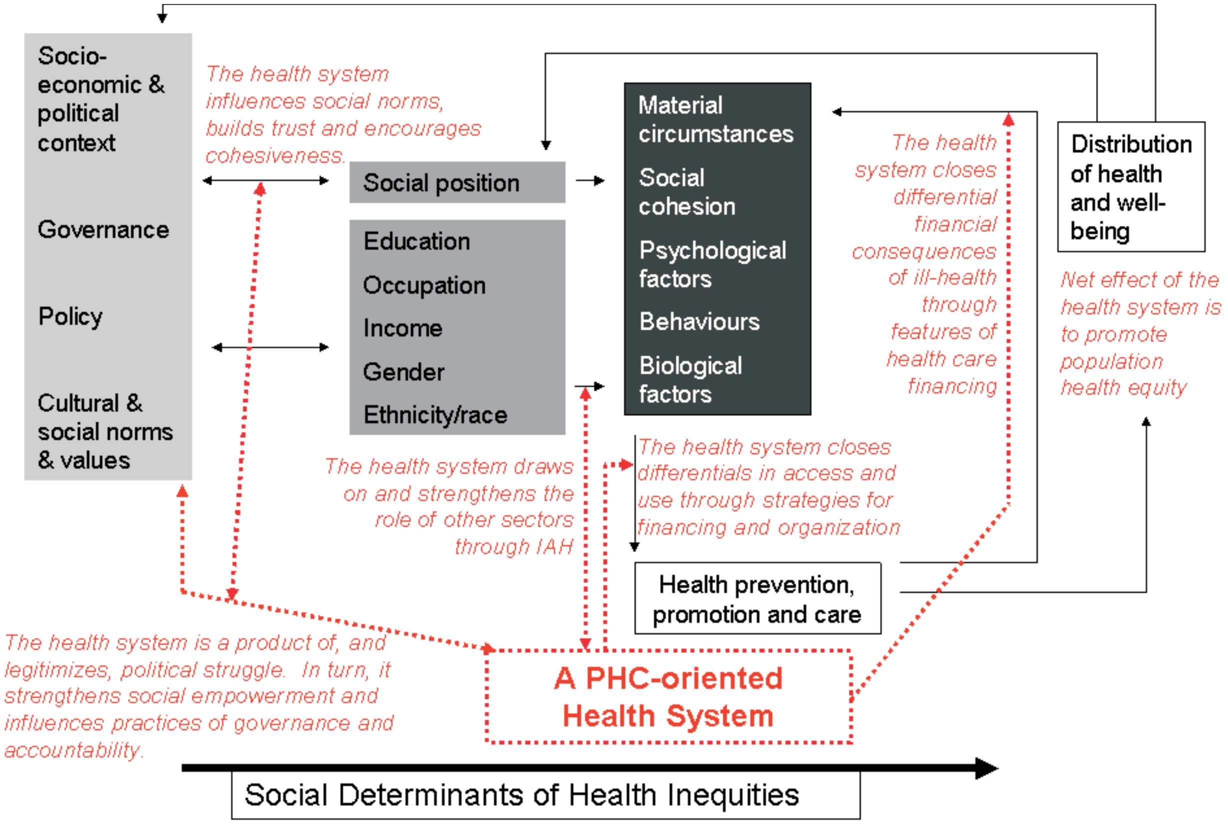


Figure 7. The Health System as a Social Determinant of Health: Opportunities for Positive Intervention.

The USPHS Study of Untreated Syphilis in the Negro Male in Context

As a background, it is interesting to view the demographical illustration which Simpson and Schuman (1954) derived of the Macon County tenant farmers and share croppers, who were victims of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male; the following description dictates more specifics of the characteristics of the men.

> Most of the study subjects were farmers and all were 25 years of age or over. They were predominantly men with families who had acquired responsibilities and had become well integrated into a community life and a folk culture which responds to

> change very slowly. Geographic isolation was a factor in favoring the unchanging nature of the group. (p. 692)

Williams and Williams (2011) clarified the intent of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male, and the substantiation of the profound deception. Williams and Williams (2011) conveyed,

> The United States government, via its Public Health Service (PHS), presumably acting on the behalf of the American people, conceived, designed, funded, conducted and sustained the study for four decades. That the actual ending of the study was occasioned by its exposure by a national press report, as contrasted with a voluntary decision initiated by the PHS, is profoundly problematic. Succinctly stated, the PHS's termination of the study was a fortuitous act; hence, arguably, the cessation of the Study was, in the language of ethics, a nonvoluntary act. The consequence of this nonvoluntary action is enormous; it leaves unaddressed—even today—an understanding of the full and comprehensive intent of the study, including the motives for, and objectives of the study. (p. 69)

The exact sample size of the population varies according to researchers; however, according to Rivers, Schuman, Simpson, and Olansky (1953),

> In beginning the study, schedules of the blood drawing clinics throughout the county were announced through every available churches, schools, and community stores. The people responded willingly, and 600 patients were selected for the study–400 who had syphilis and, for controls, 200 who did not. The patients who had syphilis were all in the latent stage…. (p. 391)

Warren (2011), Director of the Tuskegee University National Bioethics Center, has extensively reviewed and contemplated varied dilemmas of the unethical study recounted,

> …what is known is that the study consisted of 399 syphilitic Negro males, who never received treatment, 201 nonsyphilitic Negro males, with 275 of these syphilitic Negro males having been given some level of treatment during the first two years of the syphilitic process. Thus the study participants were all black men and their ages ranged between 25 and 39 years when the study began. They all supposedly lived in Macon County, Alabama; some were married and some were not. Their education and income varied even though they were reported as poor and uneducated. Various accounts of the event suggest that the men knew what was going on and volunteered for various benefits. (p. 142)

Some would argue that some of the men were injected with the syphilis bacteria, while others convey that some of the men were treated for syphilis (Riverby, 2011). Regardless of the varied interpretations or recants pursuant to the number of participants, treatment measures, presumed inoculation with the syphilis bacteria, an agreement exists for most scholars that the major anticipated outcome for the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male was death of the victims for autopsy analysis, with the pseudoexperiment occurring without informed consent (Brandt, 1978). Participants in the subject group had latent syphilis. Efforts were made by the USPHS to keep the men from obtaining treatment for syphilis.

Riverby (2011) conveyed a different lens relative to treatment of the Negro men in the study. Riverby (2011) posited,

> Ultimately, the Tuskegee Study was of undertreated rather than of purely untreated syphilis. Between 1932 and 1936, some men in the subject Arm of the study had some

> of then known treatments of neo-arsephenamine and bismuth, even if never the amounts recommended for "cure" (as was common throughout the country at that time). Of the seventy-one survivors with patient records, nearly thirty reported receiving some kind of treatment of heavy metals treatment in the 1930s and early 1940s. Some of the men who survived into the antibiotic era were able in various ways, often unknowingly, to slip out of the control of the PHS and receive penicillin, sometimes for their syphilis at other time for other ills. (p. 25)

In reviewing a document written by the Surgeon General H. H. Cumming during the time period of the study, in eliciting continued support from R. R. Moton, President of Tuskegee Institute, for use of the Tuskegee Institute Hospital, according to Brandt (1978), the following explanation in narrative form in a letter from Cumming to Moton in 1932 stated:

> This study which was predominantly clinical in character points to the frequent occurrence of severe complications involving the various vital organs of the body and indicates that syphilis as a disease does a great deal of damage. Since clinical observations are not considered final in the medical world, it is our desire to continue observation on the cases selected for the recent study and if possible to bring a percentage of these cases to autopsy so that pathological confirmation may be made of the disease processes. (p. 24)

Brandt (1978) conveyed the USPHS utilized tactics of, "deceptions and inducements" throughout the study to keep the men uninformed of the projected long-term outcomes, more specifically for purposes of autopsy (p. 23). Brandt (1978) provided the conceptualization of the study more clearly stated by Vonderlehr, a physician and then on-site director of the study, "… it is not my intention to let it be known that the main object of the present activities is to bring the men to autopsy" (p. 25). Rivers et al. (1953) provided a more concrete analysis of long-term goals of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male and clarified,

> A most important phase of the study was to follow as many patients as possible to postmortem examination, in order to determine the prevalence and severity of the syphilitic disease process. Cooperation of patients with this plan was sought by offering burial assistance (through a private philanthropy, the Milbank Memorial Fund) on condition that permission be granted for autopsy. For the majority of these poor farmers such financial aid was a real boon, and often it was the only 'insurance' they could hope for. The Federal Government offered physical examinations and incidental medication, such as tonics and analgesics, but was unable to provide financial assistance on a continuing basis. The Milbank Memorial Fund burial assistance made it possible to obtain a higher percentage of permissions for post-mortem examination than otherwise would have been granted. (p. 392)

One of the experimental study participants stated emphatically that he was never informed that he had syphilis and did not equate "bad blood" with the curable disease as the Centers for Disease Control (CDC) conjectured. Mr. Charles Pollard declared, "But I never heard no such thing. All I knew was that they just kept saying I had the bad blood – they never mentioned syphilis to me, not even once" (Jones, 1993, p. 5). Mr. Pollard confirmed, "they been doctoring me off and on ever since, they gave me a blood tonic" (Jones, 1993, p. 5).

According to Jones (1993), Dr. J. W. Williams, one of the Interns who assisted with the study in 1932 at John H. Andrews Hospital in Tuskegee, shared from his analysis, the subjects "thought they were being treated for rheumatism or bad stomachs. We didn't tell them we were looking for syphilis; I don't think they would have known what that was" (Jones, 1993).

Lack of an Ethical Framework

Thomas and Quinn (1991) situated the lack of an ethical framework of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male. Thomas and Quinn (1991) conveyed,

> Lack of medical care in Macon County meant that many of the study participants had never been treated by a physician. The PHS physicians, believing that their patients would not understand clinical terms, did not even attempt to educate them about syphilis. Participants were not informed that they suffered from a specific, definable disease that was contagious and transmitted through sexual intercourse. Nor were they told that the disease could be transmitted from mother to fetus. The PHS clinicians translated medical terms into local language. Syphilis became 'bad blood,' a phrase that Black people of the rural South used to describe a variety of ailments. When the PHS physicians announced that they had come to test for 'bad blood,' people turned out in droves. (p.1501)

Rivers, et al. (1953) revealed the essence and significance of the era and the significance of the exploitation, which indicated,

> Having a complete physical examination by a doctor in a hospital was a new experience for most of the men. Some were skeptical; others were frightened and left without an examination. Those who were brave enough to remain were very pleased. Only one objection occurred frequently: the 'back shot,' never again! There are those who, today,

> unjustifiably attribute current complaints (backaches, headaches, and nervousness) to those spinal punctures. (p. 392)

William and Williams (2011) clarified the overall intent of the study of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male. William and Williams (2011) conveyed,

> The United States government, via its Public Health Service (PHS), presumably acting on the behalf of the American people, conceived, designed, funded, conducted and sustained the Study for four decades. That the actual ending of the Study was occasioned by its exposure by a national press report, as contrasted with a voluntary decision initiated by the PHS, is profoundly problematic. Succinctly stated, the PHS's termination of the study was a fortuitous act; hence, arguably, the cessation of the Study was, in the language of ethics, a nonvoluntary act. The consequence of this nonvoluntary action is enormous; it leaves unaddressed—even today—an understanding of the full and comprehensive intent of the study, including the motives for, and objectives of the study. (p. 69)

To provide further clarity to the devastation of latent syphilis, and the violent nature of the disease, Elders (2011) stated, at the time of the exposure of the study in 1972, 74 of the subjects from the test group were alive, 28 of the Negro males had died of syphilis, 100 Negro males had died from syphilis-related complications, at least 40 wives were infected from the disease process and 19 children had acquired congenital syphilis at birth.

Brandt conveyed that being apologetic for the study did not surmount to the ramification and significance of the ethical violations manifested, as well as the damage and far reaching multigenerational effects of the USPHS Tuskegee Study of Untreated Syphilis in the Male Negro. Collateral effects of the damage from the study of non-treatment was fueled by the stereotypical beliefs of the less than human status of Negroes, thus jeopardizing the regional Negro community as a whole.

Brandt (1978) posited,

> These apologies, as well as the Health Education and Welfare (HEW) *Final Report*, ignore many of the essential ethical issues which the study poses. The Tuskegee Study reveals the persistence of beliefs within them medical profession about the nature of blacks, sex, and disease — beliefs that had tragic repercussions long after their alleged 'scientific' bases were known to be incorrect. Most strikingly, the entire health of a community was jeopardized by leaving a communicable disease untreated. There can be little doubt that the Tuskegee researchers regarded their subjects as less than human. As a result, the ethical canons of experimenting on human subjects were completely disregarded. (p. 27)

Many studies cite the legacy of the Tuskegee non-therapeutic experiment with inhibiting proper health care agency of Black Americans in various realms of the healthcare sector. Jones (1993) reiterated,

> The Tuskegee Study had nothing to do with treatment. No new drugs were tested; neither was any effort made to establish the efficacy of old forms of treatment. It was a non-therapeutic experiment, aimed at compiling data on the effects of the spontaneous evolution of syphilis on black males. (p. 2)

It has been theorized that the legacy of the study continues to hinder the relationship of Black Americans in the biomedical professions, and in more specific areas of: (a) routine preventive care, (b) participation in clinical trials and (c) organ donation requests (The Final Report of the Tuskegee Syphilis Legacy Committee, 1996).

The Final Report of the Tuskegee Syphilis Legacy Committee (1996) posited,

> In the almost 25 years since its disclosure, the Study has moved from a singular historical event to a powerful metaphor. It has come to symbolize racism in medicine, ethical misconduct in human research, paternalism by physicians, and government abuse of vulnerable people. (Para 4)

Poverty in Alabama's Black Belt Counties

Farmer (2002) acknowledged the interrelationship of poverty, human suffering and the connection to structural violence. Farmer (2002) posited,

> As the twentieth century draws to a close, the world's poor are the chief victims of structural violence – a violence which has thus far defied the analysis of many seeking to understand the nature and distribution of extreme suffering. Why might this be so? One answer is that the poor are not only more likely to suffer, they are also more likely to have their suffering silenced. (p. 9)

To attest to the uniqueness of poverty in the Black Belt region, a critical review of the epoch and historicity of specific variables and the context of time, space and place. Flynt (2011) surmised,

> Since the Civil War, Alabama has been one of the nation's poorest states. In the 2000 U.S. Census, …Alabama was the seventh poorest state, with 16 percent of its residents living in poverty, as compared with a U.S. average of 12 percent. The state also contained eight of the nation's 100 poorest counties. The origins of this poverty are complex. Some states are poor because they lack natural resources. That is not the case in Alabama, which contains abundant water and mineral wealth. So the roots of poverty must be found in its social, political, and economic policies. (Para I)

According to the U.S. Census (2010), “The South was the only region to show increases in both the poverty rate and the number in poverty—16.9 percent and 19.1 million in 2010, up from 15.7 percent and 17.6 million in 2009” (p.18).

Allen-Smith and Morris (2000) shared common demographics of the poor in the United States. The following traits are similar and are inclusive: (a) racial or ethnic minorities, (b) female-headed households, (c) are children, (d) absence of a husband in the household, (e) poorly educated, (d) work-limiting disabilities, and (e) live in nonmetropolitan areas. The poor in the rural South have regional variation in specific poverty indicators. Suitts (2010) posited,

> Ten of the 11 states in the nation where at least 1 in every 10 children were in extreme poverty are in the South. Mississippi had the largest proportion—14 percent. Louisiana, West Virginia, Kentucky, and Alabama followed at 11 to 12 percent. Arkansas, South Carolina, Tennessee, Oklahoma, and Texas had 1 child in every 10 in extreme poverty. New Mexico with 11 percent was the only non-Southern state with the nation’s highest rates of extreme child poverty. (Para II)

Swanson (1995) et al. conveyed there are many causes of poverty in the rural Black Belt counties, encompassing an: (a) entrenched legacy of discrimination, (b) multigenerational transmission of fears, (c) values and assumptions shaped by a chattel history of slavery, (e) limited choices of education, (f) employment which is marginal, (g) sharecropping, and (f) segregation. To position the poverty status in Alabama, Flynt (2011) posited, “The state’s long history of slavery, segregation, and racial discrimination helps explain the extremely high rate of poverty among African Americans” (Para II).

Allen-Smith, Wimberley and Morris (2000), postulated on the uniqueness of rurality associated with regional variations of the Black Belt and the South. Allen-Smith, Wimberley and Morris (2000) surmised,

> While the South as a whole is more rural and impoverished than other U.S. regions, this is largely due to the poor conditions in the Black Belt. In addition to region and rurality, a third feature of the pattern is race. It is in the Black Belt that the South's poor socioeconomic conditions are most concentrated. Policy and program attention are needed for regional solutions that take rurality and race into account along with demographic and other subregional characteristics. (p. 319)

Probst et al. (2002) reflected on the differences of poverty states on racial constructions. Probst et al. (2002) posited, “Typically, counties with high concentrations of minorities have income and assets that are two thirds or less of the national average” (p. 22).

The applicability of time and space of Black and Northern European Americans is distinguished, Probst et al. (2002) stated,

> Minorities in non-metro areas are more likely to experience poverty than are their white peers. Poverty and health care are intertwined: persons without resources cannot afford health services, and communities without resources have difficulty attracting and retaining health care providers. (p. 22)

Child poverty is significant in the South as a whole. According to Suitts and Wollaston (2010), “The rate of extreme child poverty in the South was nine percent in 2008. The collective rate for the South’s counties too sparsely populated to be reported individually was 11.6 percent—almost one-third higher” (p. 8). In comparison regions of entrenched poverty, Suitts and Wollaston (2010) conveyed,

> The South's rate of extreme child poverty in rural small-population areas far exceeds those in all other regions. This difference is probably explained by the region's Black Belt counties, named for the rich, dark soil where the South's large plantations once grew cotton. This subregion has been the location for much of the nation's most persistent poverty for decades. (p.13)

The conceptualization and measurement of poverty cannot be construed on a monetary basis alone. Other variables have to be considered. Suitts and Wollaston (2010) confirmed,

> Independent experts of the Human Rights Council of the United Nations argue that the United States understates extreme poverty by limiting the definition of poverty solely to a calculation of income. This international agency recognizes two additional types of extreme poverty: (1) extreme underdevelopment of human capacity, as measured by indicators such as literacy and school enrollment rates, lack of adequate education or health care, and life expectancy or infant mortality rates; and (2) social exclusion of individuals and groups as "outsiders" in the social hierarchy, as measured by obstacles to their participation in society; racial, ethnic, and other forms of discrimination; and denial of their rights within the existing legal system. (p. 13)

Suitts and Wollaston (2010) asserted most often the definition of extreme poverty in the United States includes only those persons in households whose income, as determined by the US Census Bureau, falls *below* 50 percent of the federal poverty line. In 2008, the threshold of poverty for a household of four persons was $22,025, or $5,506 per person. This income amounts to $15.09 per day for each of the four persons in the household. A child in extreme poverty lives in a household where the income is *less* than half that amount—below $7.54 per day for each person. (p. 5)

The Continuance of Institutional, Systemic and Systematic Barriers in the Black Belt South

The woes of the Black Belt sub-region continue to present major problems with inequitable living standards for most Black Americans who reside in the area. Poor Whites can also have problems associated with financial strain. Persistent problems associated with poverty have been consistent and multigenerational. Structural barriers associated with hegemonic and endemic systemic political, economic and racial issues remain paramount and virtually unchanged. Political power gained by Black Americans often times yields to lip service in some metro and non-metro Black Belt counties. A recent example of maintaining the status quo is an example of the systematic hegemonic ideology which continues and embraced by the majority conservative Republican legislative body, in the State of Alabama is the recent passage of a new controversial immigration law, Beason-Hammon Alabama Taxpayer and Citizen Protection Act, H.B. 56 (HB56). (Alabama State Legislative 2010).

The controversial immigration law targeted the Latina subpopulation and was passed on June 9, 2011. While the passage of this law was not aimed specifically at Black Americans, the overall tone certainly provides evidence of an enduring legacy of bias against the “other”. According to Quesada, Hart, and Bourgois (2011),

> Latino migrant laborers are a population especially vulnerable to structural violence because their economic location in the lowest rungs of the US labor market is conjoined with overt xenophobia, ethnic discrimination, and scapegoating. Simultaneously perceived as unfair competitors in a limited-good economy they are subjected to a conjugation of economic exploitation and cultural insult.(p.1)

The Southern Poverty Law Center (SPLC; 2012) posited, “The law was forged within a legislative debate rife with stereotypes, misinformation, incendiary rhetoric and bigotry” (p. 4). The SPLC (2012) posited,

> …the harshest anti-immigrant law in the nation—a law that virtually guarantees racial profiling, discrimination and harassment against all Latinos in Alabama. HB56 attacks not only “every aspect” of an immigrant’s life in Alabama—but also basic human dignity and our most fundamental ideals as a nation. (p. 3)

The Southern Poverty Law Center (2011) commented on the historical authenticity maintained by the State of Alabama in the passage of HB56 with a lack of concern for issues of associated legalities and of potential economic downturn in comparison to the afore-referenced problems of a sister Black Belt state that previously passed anti-immigration legislation. The Southern Poverty Law Center (2011) posited,

> HB56 is a self-inflicted wound—short-sighted lawmakers unable to see beyond the most immediate political opportunity. Though the impact of similar anti-immigrant laws in Arizona and Georgia clearly foreshadowed its legal and economic fallout, HB56 was passed with little regard for the hardships those states have experienced. The result is a crisis that harkens back to the bleakest days of Alabama’s racial history. It is a crisis that could have been avoided—one that certainly must end now. (p. 34)

HB56 provides new specificity to the landscape of enduring and entrenched Jim Crowism—as is explicitly targeting those with less power in the structure and the violence which ensues in such situations and circumstances, albeit overt actors are present in this situation, the Alabama conservative Republican legislative body. Covertly, systemic and systematic laws prevent potential from being actualized. Quesada et al. (2011) indicated,

> The vulnerability of Latino migrants is exacerbated by their interactions as economically disenfranchised laborers in a society that regards them as criminals and devalues their individual and cultural worth. This devaluation is a routinized, lived experience shared by Latinos throughout the US that is not confined to those lacking legal status. (p.4)

Potential and actualized losses in varied sectors associated with H.B.56 will have a negative impact on the state. According to the Baxter(2012) the following areas will or have been impacted, (a) projected total losses up to $10.8 billion, or 6.2 percent of Alabama's Gross Domestic Product (GDP), (b)140,000 jobs, (c) $264.5 million in state tax revenue, (d) $93.1 million in local tax revenue, (d)detrimental damage to agriculture, (e) damage to foreign investment; an actualized loss of $80 million from the Spanish bank BBVA Group, (f) "damage to social and civil rights" (p. 20).

There are many variables in the expanded Black Belt in Alabama which continue to plague the area as a whole. Adequate health care is lacking and education can be substandard. Although legislation, most recently in the State of Alabama Executive Order Number 5—January 26, 2011, which rescinds previous orders—have failed to change the infrastructure in the Black Belt area. Ingrained Jim Crowism with a chattel paradigmatic construction is endemic and pervasive, given historical specificity. The overall attempt at legislation to provide a rural Development Office with a goal to advance and improve development in healthcare, education and economics will perhaps offer to some a renewed trust, hope and fervor from a governmental system which has not embraced all people in the state of Alabama, nor the Black Belt counties (Executive Order number 5).

A History of Health Disparities and Unequal Health

Nelson (2009) postulated,

> Health care disparities are not new—they are a persistent relic of segregation and inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention (and in some cases, explicit blessing of inequality) for over 100 years after the end of the Civil War. Even less than 40 years ago, minorities routinely received inequitable care in segregated settings, if care was received at all. The nation's nascent civil rights laws had yet to make a significant dent in practices such as medical redlining and de facto segregation of health care facilities. Today, these problems are largely ameliorated, but the contemporary health care context remains shaped by this history. (pp. 2–3)

According to the Sullivan Commission (2004) on the national level, "From cancer, heart disease, and HIV/AIDS to diabetes and mental health, African Americans, Hispanic Americans, and American Indians tend to receive less and lower quality health care than whites, resulting in higher mortality rates" (p. i). "Conditions arising from cardiovascular disease are the leading cause of death in America, cutting across all racial and ethnic groups, socioeconomic levels, and affecting both men and women" (Civil Rights Commission, 2010, p.1).

Overall health status in the U.S. has improved significantly as demonstrated by the dramatic increase in life expectancy for whites (from 47.6 to 77 years) and blacks (from 33 to 72.2 years). However, in spite of the many improvements in health over several decades, significant gaps still exist by race, ethnicity, gender, disabilities, and other related sub populations with respect to premature death and preventable disease. These gaps may in part be related to demographic changes in the U.S. population. (Civil Rights Commission, 2010, p. 7) Nelson (2009) conveyed the following data relative to disparities for people of color,

> (a) the prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States;(b) among African Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for white Americans; (c)although infant mortality decreased among all races during the 1980-2000 time period, the black-white gap in infant mortality widened; and (d)while the life expectancy gap between the African Americans and whites has narrowed slightly, African Americans still can expect to life 6-10 fewer years than whites, and face higher rates of illness and mortality; (e) a recent analysis of 1991 to 2000 mortality data concluded that had mortality rates of African Americans been equivalent to that of whites in this time period, over 880,000 deaths would have been averted.(p.3)

Chapman and Kemp (2003) conveyed, “Eliminating disparities in health outcomes is a serious public health concern in Alabama” (p. 5). According to the Alabama Health Disparities Status Report (2010),

> Alabama has been ranked as one of the worst states in terms of health as compared to the nation for a number of years. Not only is the overall health poor in Alabama when compared to other states, but the health disparities between African Americans and Whites are considerable. (p. iv)

The Alabama Health Disparities Status Report (2010) denotes in the state of Alabama, “Health disparities include, but are not limited to, the lack of physicians in rural areas, low health literacy, unequal treatment, and exposure to environmental risks” (p. 2).

According to the Department of Public Health Office of Minority Health in the state of Alabama, 26 percent of residents describe themselves as Black Americans, which is the sixth highest percentage in the United States. The majority of Black Americans reside in rural counties in the south central region and larger cities. Over 36 percent of Black Americans reside in Montgomery, Birmingham, Mobile, and Huntsville. Of the afore-referenced counties, Montgomery County reflects a racial population of 54.7 percent. The largest population of Black Americans resides in the Black Belt counties of Bullock, Dallas, Greene, Hale, Lowndes, Macon, Marengo, Perry, Sumter, and Wilcox. Between the years of 2000 and 2010, there was a decrease of Black residents in the state of Alabama, by over 19.5 percent of 1,555,930 in 2000 and 1,251,311 in 2010. Overall, Black Americans comprise 82.75 percent of the minority population in the State of Alabama. Disparities exist in most health status indicators for Alabama's Black American population. A focus in the following areas required initiatives and objectives for improvement in 2010 for the Black American population inclusive of: (a) Life expectancy, (b) Hypertension, (c) Renal Disease, (d) Motor vehicle fatalities, (e) Homicides, (f) Infant mortality, (g) low birth weights, (h) adolescent pregnancy, (i) prenatal care, (k) syphilis, (l) suicide, (m) diabetes, (n) HIV infection/AIDS.

The Sullivan Commission reiterated the changing landscape of demographics in American society. The state of Alabama bears relevance to findings from the Commission (Table 1). The Office of Minority Health in the state of Alabama denotes demographical changes in the minority population in the state (Retrieved from http://www.adph.org/minorityhealth/Default.asp?id=718). For example, in the state of Alabama, the Latino population increased by approximately 208 percent between the years of 1990 and 2000. This increase of the Latino population was the seventh greatest percentage increase among all 50 states. In 2000, Alabama's Latino population of 75, 830 exceeded the projected total of the U.S. Census Bureau for the year 2025, by nearly 13,000 constituents. This finding bears relevance to the Alabama legislature passage of the Beeson Hammond Immigration Bill. The racial mix of Alabama's Latino population is for the most part Mexican; however, there are also great number of Puerto Ricans, Guatemalans, Colombians, Salvadorians, Brazilians, and Panamanians (Retrieved from http://www.adph.org/minorityhealth/Default.asp?id=718).

> The median age of the Latino population in Alabama is 24.9 years. The health status of the Latino population in Alabama simulate those of Black Americans, in addition to: (a) pneumonia, (b) liver disease, (c) influenza, (d) alcoholism, (e) perinatal conditions, (f) injuries, (g) dermatitis, (h) urinary tract infections, (i) depression, (j) tuberculosis, and (k) homicide. Also, the lack of health insurance is a problematic area for this minority group (retrieved from: http://www.adph.org/minorityhealth/Default.asp?id=718).

The plight of Latino workers provides the agony that is assumed from a migrant workers view framed from a quote on the Minority Health site, a migrant worker thusly stated, "We confront illnesses from the chemicals that they apply in the fields. Some suffer from rashes on the body, others headaches, back aches and what is worse we have no health insurance..." (Retrieved from: http://www.adph.org/minorityhealth/Default.asp?id=718). The health care disparities of the Latino subpopulation group in the state of Alabama, evokes relevance to distinct realities of findings from the Sullivan Commission (2004).

The Sullivan Commission observed (2004),

> As the population has become increasingly diverse, glaring disparities in the quality of care, especially for racial and ethnic minorities, have led to thousands of premature deaths each year and incalculable hours of lost productivity, pain, and suffering. Many complex factors are at play. (p. 1)

Table 2

Population and Minimum Percentage Change for Selected Races, 2000 vs. 2010

Race	2000 Census	2010 Census	Minimum % Change
Total	4,447,100	4,779,736	+7.48
White	3,162,808	3,275,394	+3.55
Black	1,555,930	1,251,311	-19.5
American Indian/Alaska Native	22,430	28,218	+25.8
Asian Indian	6,900	13,036	+88.9
Chinese	6,337	9,436	+48.9
Filipino	2,727	4,952	+81.5
Japanese	1,966	2,391	+21.6
Korean	4,116	8,320	+102.1
Vietnamese	4,628	7,398	+59.9

Source: Alabama Department of Public Health, Office of Minority Health

As uncovered in the literature, the relationship between educational attainment and health status was confirmed by The Alabama Health Disparities Status Report (2010) which conveyed,

> There is a strong relationship between educational attainment and health status. According to the 2000 Census of Population, nearly one-third (30.3 percent) of all rural Alabama residents age 25 years or older had less than a high school education. This exceeds 20.2 percent of urban residents in this age group with less than a high school education. Providing rural students with the educational opportunities to compete with

> urban counterparts may help in reversing the health status of rural Alabama residents. (p. iv)

A Disparity in Health Care Providers

"The shortage of health care professionals is a major problem in Alabama. The shortage designations include Medically Underserved Areas (MUA), Health Professional Shortage Areas (HPSA), Mental Health Professional Shortage Areas (MHPSA), and Dental Health Professional Shortage Areas (DHPSA)" (The Alabama Health Disparities Status Report, 2010, p. 2). The Alabama Health Disparities Status Report (2010) related problematic variables of access to health care in rural Alabama with "60 primary care health professional shortage areas" in the state (p. v). In comparison to rural vs. urban areas, "the potential number of patients for each rural Alabama primary care physician in 2006 was approximately 2,160 compared to only1,250 for those practicing in urban counties" (p. v). Eight rural counties in the state do not have a hospital. Out of 55 hospitals, 35 don't provide labor and delivery services. The time for first responders to the scene of an emergency is over 27 percent higher, in comparison to times in urban areas. For rural Alabama residents, motor vehicle accident mortality rates in 2005–2007 were approximately 46 percent higher than for urban county residents which "was more than double the rate for the nation" (p. v). "Rural Alabama hospitals had 25.1 general hospital beds per 10,000 residents in 2009 compared to 45.0 general hospital beds per 10,000 residents in urban counties (The Alabama Health Disparities Status Report, 2010, p. v). In addition, "the potential number of patients for each rural Alabama dentist in 2007 was approximately 3,845 compared to 1,774 for those practicing in urban counties" (The Alabama Health Disparities Status Report, 2010, p. v).

The shortage of health care providers in the state of Alabama parallels findings from the Sullivan Commission on Diversity in the Healthcare Workforce Report (2004) which indicated, "… an imbalance in the makeup of the nation's physicians, dentists, and nurses. This imbalance contributes to the gap in health status and the impaired access to health care experienced by a significant portion of our population" (p. iv). The Commission further postulated, "The lack of minority health professionals is compounding the nation's persistent racial and ethnic health disparities" (The Sullivan Commission on Diversity in the Healthcare Workforce, p. i).

The Commission found in 2004, "…African Americans, Hispanic Americans, and American Indians, …constitute nearly 25 percent of the U.S. population, these three groups account for less than 9 percent of nurses, 1.6 percent of physicians, and only 5 percent of dentists" (p. i). The Sullivan Commission on Diversity in the Healthcare Workforce (2004) found

> …African Americans, Hispanics, American Indians, and certain segments of the nation's Asian/Pacific Islander population are not present in significant numbers. Rather, they are missing! While some outstanding physicians, dentists, and nurses are minorities, access to a health professions career remains largely separate and unequal. (p. vi)

The Institute of Medicine Study on "Unequal Treatment" (2002) substantiated the significance of differences of cultural relativism, factors associated with a lack of access to the health care system, in combination with soaring poverty rates and unemployment, contributing to the extensive disparities in health outcomes and status of ethnic and racial groups. "In 2008, more than 35 million Americans lived in areas that were designated as underserved – lacking primary care physicians, dentists and mental health professionals" (U.S. Civil Rights Commission, 2009, p. 3).

Health Disparities in Alabama

The Institute of Medicine Study on Unequal Treatment (2002) substantiated the significance of differences of cultural relativism, factors associated with a lack of access to the health care system, in combination with soaring poverty rates and unemployment, contributing to the extensive disparities in health outcomes and status of ethnic and racial groups.

> The leading health indicators for Alabama include: cardiovascular conditions and diseases, cancer, diabetes, HIV/AIDS, infant mortality, and mental health illness. Health disparities include, but are not limited to, the lack of physicians in rural areas, low health literacy, unequal treatment, and exposure to environmental risks. (The Alabama Health Disparities Status Report, 2010, p. 2)

Disparities in Alabama for obesity when reviewed by race, income and education, the racial group with the highest percentage of obesity was Black Americans earning less than $25,000 annually. In Alabama, the average obesity percentage in 2009 was 31.6, albeit some counties had a 43 percent adult rate of obesity. In 2007 and 2008, the obesity rates became closer for those without a high school diploma to those with a diploma. For those with two or less years of post high school education, an increase in the rate of obesity also occurred (pp. 5–6).

Disparities in cigarette use in the state of Alabama denotes those with less than 12 years of education having smoking rates of 35.6 percent, while those with some post high school education manifested a rate of 23.9 percent. College graduates have a rate of 11.6 percent. Overall, the percentage of European Americans was 22.3 percent and 20.3 percent for Black

Americans. The greatest disparity is for Black males having the highest rate of 27.5 percent when compared to European American counterparts (p. 8).

Cancer. Significant disparities in cancer incidence and mortality are evident in minority and underserved population groups in the state. From 1997–2006, African American men (59.3 per 100,000) had a 14.7 percent higher colorectal cancer incidence rate than White men (51.7 per 100,000). Compared to White females, breast cancer incidence rates are lower among African American women in Alabama, but the mortality rates are higher. Research shows African American men are more likely to develop prostate cancer and twice as likely to die from it than other races (The Alabama Health Disparities Status Report, 2010, p.11).

Heart disease. "In 2008, the mortality rate for heart disease was highest among black males with a rate of 226.6 per 100,000 population …. black males showed the highest stroke death rate of 58.0 per 100,000 population" (The Alabama Health Disparities Status Report, 2010, p. 19).

Diabetes. In 2008, "the diabetes mortality rate for Whites was 25.4 per 100,000" (The Alabama Health Disparities Status Report, 2010, p. 23). For Black Americans, the diabetes mortality rate "was approximately 43.3 per 100,000, …. The prevalence of diabetes among African Americans is higher than the prevalence of diabetes among Whites within every age group" (The Alabama Health Disparities Status Report, 2010, p. 23).

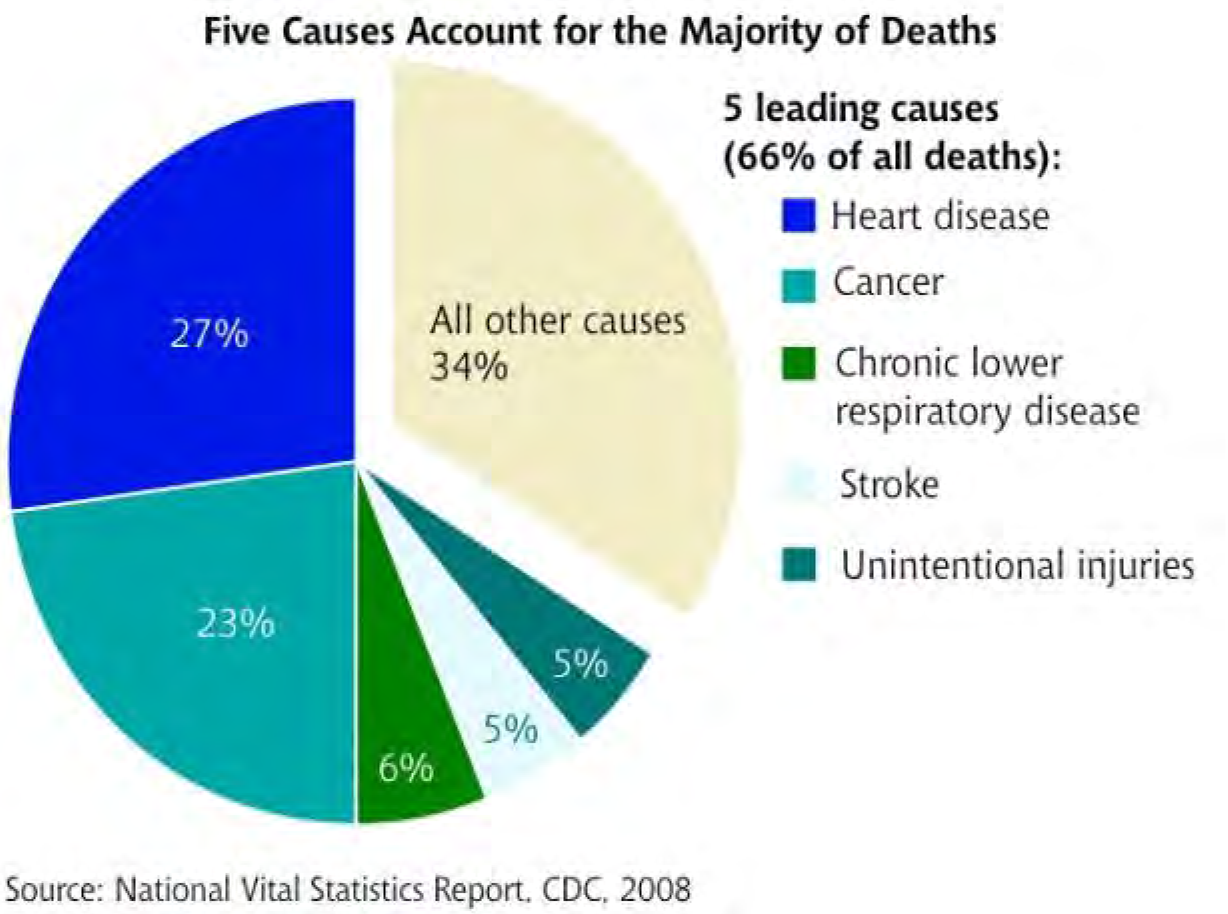
Hypertension (HTN). Nationally, a large study of gender and racial disparities found that 76 percent of White men and 71 percent of White women had blood pressure controlled to an optimal level, while 63 percent of both African American men and women had blood pressure optimally controlled (The Alabama Health Disparities Status Report, 2010, p. 17).

Human immunodeficiency virus (HIV). African American males represent 26 percent of the state's population; however, 63.8 percent (10,548) of all reported HIV/AIDS in Alabama are from this group. African American females represent 19.2 percent (3,183) of all HIV/AIDS reported.

Infant mortality. Alabama's African American infant mortality decreased from a rate of 14.1 (per 1,000 live births) in 2008 to 13.3 per 1,000 live births in 2009, the lowest it has ever been, and it was very close to the 2007 national rate for Blacks at 13.2. White infant mortality decreased from a rate of 7.6 in 2008 to 6.2 in 2009, also the lowest in history. The White rate continued to be above the national average of 6.5 in 2009 (The Alabama Health Disparities Status Report, 2010, p. 30). In Alabama, "49.6 percent of births were covered under Medicaid in 2009" (The Alabama Health Disparities Status Report, 2010, p. 35).

Mental health –suicide rate. Youth suicide rates vary widely among different racial and ethnic groups. In 2001, White youth had a suicide rate of 11.5 per 100,000, compared to rates of 7.3 for African Americans, 6.1 for Hispanics, 6.4 for Asian Americans, and 18.8 for American Indians and Alaskan Natives (The Alabama Health Disparities Status Report, 2010, p. 37).

> According to Mokdad, et al. (2004), in the United States the CDC revealed the leading causes of death in 2000 were tobacco (435,000 deaths; 18.1% of total US deaths), poor diet and physical inactivity (400,000 deaths; 16.6%), and alcohol consumption (85,000 deaths; 3.5%). Other actual causes of death were microbial agents (75,000), toxic agents (55,000), motor vehicle crashes (43000), incidents involving firearms (29,000), sexual behaviors (20,000), and illicit use of drugs (17,000). (p.1238)



Source: National Vital Statistics Report, CDC, 2008

Figure 8. Five Leading Causes of Death

The Interrelationship of Social Determinants, the Black Male and Criminal Justice

A pervasive reality to social processes can be argued from a functionalist perspective relative to mass incarceration of nonwhite males and the risk of incarceration of nonwhite females. Franz Fanon (1963) in the *Wretched of the Earth* categorizes the impact of the effects of "reciprocal exclusivity" and the elongated effects of the detriment and devastation associated with domination and superiority. Violence becomes the central theme, evidencing the impact of the extensive and long term effects associated with domination and the "combat" occurring between the native and the settler resulting in an "armed and open struggle".

Such social conditions produce "others". The theoretical construct of anomie encompasses alterations in social processes due to a lack of integration of standard and acceptable norms. Because of the powerful influence of the hierarchal social structure "others", in this case, those disadvantaged and marginalized, participate in nonconforming behavior in an attempt to align with a material realm, which cannot be realized in socially constructive venues. Within these social conditions, which are so vastly different from dominant norms, distinct members of society become different or the "others". Within the locality of people, peculiarly subject to such pressures, an expectation is to find high rates of deviant behavior, not because the human beings comprising such are compounded of distinctive biological tendencies but because normality exists to the social situation in which they are confined (Merton, 1938).

Society creates and perpetuates differences through legitimate domination, social conditions, decolonization, and education. Perpetual distinctions of difference or "others" result in "savage inequalities" in a capitalistic society. Western and Petit (2010) conveyed,

> In the last few decades, the institutional contours of American social inequality have been transformed by the rapid growth in the prison and jail population. America's prisons and jails have produced a new social group, a group of social outcasts who are joined by the shared experience of incarceration, crime, poverty, racial minority, and low education. (p. 8)

A disparity in the criminal justice system is ingrained in the fiber of American society imposing a pervasive occurrence in the life of the Black American male, so much so until a seemly natural course occurs within the penal system with 60 percent of Black American males who drop out of school populating the system at some time in their lives. This reality denotes realism in the lives of young Black males of the permanence of their existence. *Carson and Sabol (2011) revealed*, "Between 6.6% and 7.5% of all black males ages 25 to 39 were imprisoned in 2011, which were the highest imprisonment rates among the measured sex, race, Hispanic origin, and age groups" (p. 8). Freeman (1996) indicated, "Participation in crime and involvement in the criminal justice system has reached levels as to become part of normal economic life for many young men" (p. 25). Interestingly, Myrdal (1944) surmised a perspective of the criminal justice system and the negative conjectures which influence the unjust paradigm, practices and outcomes for the Negro during the pre civil rights era. Myrdal (1944) surmised,

> The Negroes, on their side, are hurt in their trust that the law is impartial, that the court and the police are their protection, and, indeed, that they belong to an orderly society which has set up this machinery for common security and welfare. They will not feel confidence in, and loyalty toward, a legal order which is entirely out of their control and which they sense to be inequitable and merely part of the system of caste suppression. (p. 525)

Surprisingly history has continued to perpetuate the afore-referenced analysis by Myrdal. An unequal distribution of the criminal justice system has continued pervading centuries.

Carson and Sabol (2011) conveyed,

> In 2011, blacks and Hispanics were imprisoned at higher rates than whites in all age groups for both male and female inmates. Among prisoners ages 18 to 19, black males were imprisoned at more than 9 times the rate of white males. In 2011, Hispanic and black male prisoners age 65 or older were imprisoned at rates between 3 and 5 times

those of white males. Excluding the youngest and oldest age groups, black males were imprisoned at rates that ranged between 5 and 7 times the rates of white males. Among persons ages 20 to 24, black males were imprisoned at about 7 times that of white males. Among persons ages 60 to 64, the black male imprisonment rate was 5 times that of the white male imprisonment rate. In comparison, Hispanic males were imprisoned at 2 to 3 times the rate of white males in 2011. Black females were imprisoned at between 2 and 3 times the rate of white females, while Hispanic females were imprisoned at between 1 and 3 times the rate of white females. (p. 8)

According to Carson and Sabol (2011),

In 2011, imprisonment rates among age and racial groups tended to increase through age 34 before declining. The imprisonment rates indicate that about 0.5% of all white males, more than 3.0% of all black males, and 1.2% of all Hispanic males were imprisoned in 2011. Between 6.6% and 7.5% of all black males ages 25 to 39 were imprisoned in 2011, which were the highest imprisonment rates among the measured sex, race, Hispanic origin, and age groups. Slightly fewer than 3% of Hispanic males were imprisoned in each of the age cohorts between ages 25 and 39. (p. 8)

Table 3

Estimated Percent of Sentenced Prisoners under State and Federal Jurisdiction by Sex, Race, Hispanic Origin, and Age, December 31, 2011

		Males				Females			
Age Group	Total[a,b]	All [a,b]	White[c]	Black[c]	Hispanic	All [a,b]	White[c]	Black[c]	Hispanic
Total[d]	1,537,415	1,433,741	465,100	555,300	331,500	103,674	51,100	26,000	18,400
18–19	1.5%	1.5%	0.9%	1.9%	1.7%	0.9%	0.6%	1.2%	1.1%
20–24	12.4	12.4	9.9	13.8	13.8	11.2	10.4	11.5	13.0
25–29	16.4	16.3	14.4	16.5	18.8	17.4	17.2	16.5	19.6
30–34	16.6	16.5	14.4	17.1	18.7	17.5	17.4	16.9	19.0
35–39	13.8	13.7	12.8	13.8	15.1	14.8	14.9	14.2	14.7
40–44	12.6	12.5	13.4	12.1	11.7	14.1	14.1	14.6	13.0
45–49	11.1	11.0	12.9	10.6	8.9	11.8	12.1	12.7	9.2
50–54	7.7	7.7	9.5	7.4	5.6	7.0	7.2	7.7	5.4
55–59	4.1	4.2	5.4	3.8	3.0	3.2	3.3	3.1	2.7
60–64	2.1	2.2	3.2	1.7	1.5	1.4	1.6	1.2	1.1
65 or older	1.7	1.8	3.0	1.0	1.1	0.9	1.0	0.8	0.5

Sources: Bureau of Justice Statistics, National Prisoner Statistics Program, 2011; Federal Justice Statistics Program, 2011; National Corrections Reporting Program, 2010; and Survey of Inmates in State and Local Correctional Facilities, 2004.

[a] Detail may not sum to total due to rounding.

[b] Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and persons identifying two or more races.

[c] Excludes persons of Hispanic or Latino orgin. .

[d] Includes persons age 17 or younger.

Marable (2000) indicated,

> We live in a world today where prisons are among the fastest and most profitable ‘growth industries’ and in which there are currently 340,000 Americans who are employed as prison guards. Thousands of low-paid, low-skilled jobs are increasingly outsourced to prison workers, who of course lack the protection of unions and environmental and health safety standards. (p. xxxvii)

Deprivation and social exclusion contribute to the magnitude and existence of violence in the United States. Bartner (1990) reviewed cross national studies of various countries; findings revealed when countries have a high degree of economic inequality, higher levels of violence exist. Werner and Smith (1992) stated when economic inequality exists, deprived youth suffer the greatest deprivation with the risk and potential to partake in criminal and violent acts. Krivo and Peterson (1996) conveyed in the United States, the connection between violence and disadvantage, which is extreme in context, contributes to the association of violent crimes and race in America. According to Kunjufu (2001), in the criminal justice system the number of young Black males has risen insurmountably, and are housed in juvenile or adult facilities; this reality is devastating and problematic. In 2001, Kunjufu (2001) found Black American males are representative of over 50% of the entire prison population, while only comprising 6% of the national population. According to Livingston and Nahimana (2006), drug convictions account for a great majority of the arrests and convictions.

Carson and Sabol (2011) asserted in 2010, the offense which was the most serious for 237,000 convicted prisoners involved illegal drugs. Of this total, 105,600 (44.6%) were non-Hispanic black 69,500 (29.3%) were non-Hispanic white, and 47,800 (20.2%) were Hispanic.

The plight of young Black men with encounters in the penal system poses dire consequences to their healthy and holistic development, promoting the possibility of the demise of future goals with potentialities not being actualized. Due to legislation which poses stiffer sentencing, increased surveillance, and the committal of crimes which are considered violent, the presence of Black men residing in the community of their culture have become dismal. By the ages of 13–15, in part due to the drug trade having been established as a venue of survival, detention centers have become a place of residence for young Black males. The drug trade provides an opportunity for existence from an economical standpoint with young Black boys entering the trade as early as 9 and 10 years of age and often advancing to the adult penal system prior to their 18th birthday.

Inequity in sentencing is unjustifiably detrimental to the complete development of these young men, often leading to longer prison and jail terms. When reentering the community of their residence after release from prison or jail, power to negotiate as productive members of society is of null. The time in prison and/or jail has shaped every facet of these young men's development, making survival outside of the culture of a prison-like mentality foreign and virtually impossible. The appeal of the drug trade and the embracement of like cohorts become cyclical with a high rate of recidivism. The complete development of young Black men while residing in the penal system becomes whole, with inmates or more seasoned offenders replacing the paternal and maternal roles to these young men. Livingston and Nahimana (2006) indicated:

> Boys reared in communities plagued by poverty, limited opportunities, and high rates of incarceration enter the adult world economically and politically emasculated. The only reference point for self-esteem for many of them is on the street or in the juvenile detention centers where much of their formative development has occurred. These early arrests, incarceration, and prison become rites of passages and school and obtaining skills necessary for the new job market become irrelevant to them. (p. 212)

The impact of poverty and inequities has interrelationships with varied areas associated with criminality. Currie (1998) observed,

> For there is now overwhelming evidence that inequality, extreme poverty, and social exclusion matter profoundly in shaping a society's experience of violent crime. And

> they matter, in good part, precisely because of their impact on the close-institutions of family and community. (p.114)

According to Kramer (2000), youth aged from 15 to 24 are disproportionately impacted by violent acts. According to Kramer (2000), while the United States is very wealthy, more inequality exists, with a lack of commitment to providing for and supporting the poor. In fact, economic inequality and poverty in the United States, reflects an inordinate gap between the rich and the poor, more so than any of the developed nations. This finding is reflected from data collected from the Luxemburg Income Study (LIS) which provides comparative studies on inequality, poverty and governmental spending on an international basis (Kerbo 1996; Kramer, 2000; Rainwater & Smeeding 1995). Marable (2000) asserted,

> Many politicians, intellectuals and civic leaders condemn the United States on the ground that white society has systematically excluded Blacks as a group from the material, cultural and political gains achieved by other minorities. Blacks are unemployed, economically exploited and politically disfranchised because they are excluded or segregated because of caste or racial discrimination. But there is another point of issue: Blacks occupy the lowest socioeconomic rung in the ladder of America upward mobility precisely because they have been "integrated" all too well into the system. America's "democratic" government and "free enterprise" system are structured deliberately and specifically to maximize Black oppression. Capitalist development has occurred not in spite of the exclusion of Blacks, but because of the brutal exploitation of Blacks as workers and consumers. Blacks have never been equal partners in the American Social Contract, because the system exists not to develop but to *underdevelop Black people*. (p. 6)

Marable (2000) also indicated, “Underdevelopment is not the absence of development; it is the inevitable product of an oppressed population’s integration into the world of market economy and political system” (p. 7).

According to Kramer (2000), data from the LIS provided credence to the plight of poor women and children in the United States than in other countries which are industrialized indicating the status as extreme relative to other advanced nations. Data from the LIS reflect various causes relative to poverty and economic inequality. Wilson (1996), referenced the existence of poverty of the urban underclass due to an unemployment status which is concentrated in nature. A secondary labor market for this group encompasses less benefits and meager wages. Marable (2000) postulated,

> Millions of poor, working, and even middle-class whites are also being increasingly pulled into this penal leviathan as well. About one in five Americans now has a criminal record: as jobs at living wages continue to disappear, we should anticipate the prison system soon being flooded with thousands of whites, many of whom previously supported the representative legislation now responsible for their confinement. (p. xxxvii)

African American and Latino communities have borne a disproportionate burden of the adverse effects of aggressive policing and “zero tolerance” policies. Moreover as a result of prison expansion, correctional budgets in many states now equal or exceed those for education and health care (Freudenberg, 2002, p.1896).

Brutal violence exist from a socioeconomic perspective, according to Raphael (2000), the incarceration of black men, including those who are incarcerated or who have a history of incarceration negatively impact positive prospects of gainful employment. Raphael (2000) stated,

> The increasing proportion of black men that are either currently incarcerated or have been incarcerated in the past is likely to suppress their relative socioeconomic status. Having served a prison sentence worsens one's labor market prospects for a variety of reasons, and thus aggravates stubborn racial differences in employment and pay. In addition, the interruption of a prison sentence and the consequent lengthy absence of African-American males from their spouses, partners, and children is likely to hamper family formation and hasten the dissolution of existing, if not stable, family units. Given the high fraction of black men with felonious criminal history records, these collateral consequences of incarceration are quickly becoming an increasingly important source of racial inequality in the United States. In fact, one might argue that in light of the potentially permanent consequences of an incarceration spell, the high incarceration rate among black males is perhaps one of the chief barriers to their socioeconomic progress (pp. 9–10).

Relative to dropouts of young Black males, Raphael (2000) indicated:

> Similarly, increases in the proportions institutionalized are much larger than those observed for dropouts overall. For dropouts between 18 and 25, the institutionalization rate increases from 8 percent to 23 percent. For those between 26 and 40, the institutionalization rates increases from approximately 5 percent to 30 percent. For all dropouts less than 40 years of age, the institutionalized population is only slightly smaller than the population of employed men from this demographic group. For black dropouts between 26 and 30, there are actually more institutionalized than employed.

> Comparable, although somewhat muted, patterns are observed for black high school graduates. (p. 6)

According to Raphael (2004), since 1970 the institutionalization rates have increased at an astounding rate for Black men in general. "Because of their extraordinary rate of incarceration, one in every 20 black men over the age of 18 is in a state or federal prison, compared to one in every 180 whites" (Human Rights Watch, 2000, Para 10). These notable increases in the incarceration rate have occurred more substantially for young Black males and for those with a significantly less education. When reviewing these two stated dimensions of less education and being young and black, findings reveal that the most relevant and brutal increase occurs with incarceration for those young black males, who are between 25 and 40 years of age. Western and Pettit (2010) found,

> The spectacular growth in the American penal system over the last three decades was concentrated in a small segment of the population, among young minority men with very low levels of education. By the early 2000s, prison time was a common life event for this group, and today more than two-thirds of African American male dropouts are expected to serve time in state or federal prison. These demographic contours of mass imprisonment have created a new class of social outsiders whose relationship to the state and society is wholly different from the rest of the population. (p. 16)

The United States also provides less governmental benefits to compensate for the problems associated with resolute unemployment and meager earnings (Kramer, 2000). Currie (1998) concluded:

> The links between extreme deprivation, delinquency, and violence, then, are strong, consistent, and compelling. There is little question that growing up in extreme poverty

> exerts powerful pressures toward crime. The fact that these pressures are overcome by some individuals is testimony to human strength and resiliency, but does not diminish the importance of the link between social exclusion and violence. The effects are compounded by the absence of public supports to buffer economic insecurity and deprivation, and they are even more potent when racial subordination is added to the mix. And this ... helps us to understand why the United States suffers more serious violent crime than other industrialized democracies, and why violence has remained stubbornly high in the face of our unprecedented efforts of repressive control. (p. 131)

In addition, according to Kramer (2000), Frances T. Cullen in 1984 in a presidential address presented to the Academy of Criminal Justice Sciences imparted that acts of criminality are associated with a parsimony of social supports which directly impacts and connects to acts which are criminal. When social supports are inhibited, economic deprivation and social exclusion can result in violent acts, specifically so for those that are young or in their youth. Cullen (1994) posits, “The less social support there is in a community, the higher the crime rate will be” (p. 534). Research supports that crime rates are higher in communities characterized by family disruption, weak friendship networks and low participation in local voluntary organizations (pp. 534–535). In fact, Haney and Zimbardo (1998) contended, “crime control policies are a major contributor to the disruption of the family, the prevalence of single parent families, and children raised without a father in the ghetto, and the ‘inability of people to get the jobs still available’” (p. 716).

Quantitative and qualitative ethnographic studies conducted on the “underclass” noted the reality of the existence and creation of isolated inner city enclaves created from dominant economic and social forces. Such enclaves form a web of decay of what would be the protective venues of youth and their involvement in violent crimes, in essence the supportive relationships which should avert overt negative acts of criminal involvement are diminished.

The role of an intact family cannot be negated, Cullen (1994) conveyed "the more support a family provides, the less likely it is that a person will engage in crime (p. 538). Colvin and Pauley (1983) constructed a theoretical framework integrated with Marxist structural theory, which focused on processes relative to social reproduction and economic production which are inclusive of: (a) families, (b) peer groups, (c) schools, and (d) places of work. Colvin and Paul (1983) stated, "the more coercive the control relations encountered in these various socializations contexts tend to the more negative or alienated will be the individual's ideological bond and the more likely is the individual to engage in serious, patterned delinquency "(p. 515). Ideologically, working class patterns present in the home those behaviors which have been experienced in the market place which can be coercive and controlling, children are placed in schools which exert coercive controls and therewith become alienated, which allows association with other peers who are so alienated, who, therewith interact and present behaviors relative to "formed peer group control structures" interacting within the community promoting deviancy and delinquency. Deprivation and social exclusion contribute to the magnitude of violence evident in the United States.

This reality denotes the presence of more African American males in the criminal justice system than in college. Non-white males, most notably African American and Hispanic, are arrested at higher rates and receive lengthier prison sentences in comparison to middle aged white males (Petit & Western, 2004; Sheldon, 2004; Spohn & Holleran**,** 2000). The incarceration of nonwhite males result in a loss of educational and economic power thus impacting negatively political power (Manza & Uggen, 2002, 2006; Roster, 2007).

According to Mayer (2006), the significance and impact of race in the criminal justice system is representative of conflictual tension threaded through the core of American society. Minorities, notably African American and Latinos appear to have direct collisions in the comportment of the criminal justice system, victimization occurs more than any other group. Problems occur on a broad scale and directly impact various venues associated with productivity and success in American society. The imprisonment of African American and Hispanics impact the family and community as well, resulting in patterns of deviance which is often multigenerational. From a psychological perspective, the absence of family members (i.e. fathers, significant others) in the home and the community might impose feelings associated with embarrassment and humiliation, with an erosive decay in societal acceptance, a dissonance with authority figures evidenced by behavior associated with a loss of self esteem and manipulation (Townsend, 2005).

According to Petit and Western (2004), the impact of the involvement in the penal system evokes a corrosive course increasing greatly the fundamental constructs associated with issues relative to the marginality of the minority nonwhite male evoking a perpetual cycle, lacking power to maneuver successfully accustomed normed behaviors associated mores of dominant members of society. Agency relative to incarceration is restricted and confined to low wages, recidivism, unemployment, family in-cohesion, social and political insolvency. Class and behavioral distinctions associated with poverty are evidenced (Mauer, 2004).

Marable (1993) posited, “Despite the orthodox cultural ideology of the so-called melting pot, power, privilege and the ownership of productive resources and property has always been unequally allocated in a social hierarchy stratified by class, gender, and race” (p. 113). Class and behavioral distinctions associated with poverty are evidenced (Mauer, 2006).

Black American males are not the only minority so debasingly impaired. The incarnation rate of Hispanics gives credence to viable discourse in the criminal justice system. When reviewing a 10 year time lime of 1990–2000, the number of incarcerated Hispanics increased by 67 percent. In essence, nonwhite minorities (Latinos and Black Americans) are representative of two-thirds nationally of the prison population. In 2002, an incarceration rate in the United States existed at a rate of 690 per 100,000 of the population (Case, 2008).

Society creates and perpetuates differences through legitimate domination, social conditions, decolonization, and education. Perpetual distinctions of difference or “others” result in “savage inequalities” in a capitalistic society. Differences are perpetuated in social, economic, and political venues and are reflected in every system in society inclusive of healthcare, housing, education, political power, social location, position standing and economic venues which certainly impacts how a race or cultural group maneuvers in society.

According to Gil (1996), societal institutions, the conditions and quality of the lives of the constituents are so influenced with ideologies and values from the dominant member’s perspective. “Manifestations of violence are usually perceived and dealt with as discrete events. However they are actually moments of social, historical, cultural, and psychological processes or moments of gradually intensifying vicious circles…” (p. 29). Gil further clarifies the following interacting phases of social structural violence,

> (a) initiating social-structural violence within and between human societies, i.e. coercively established and ideologically and coercively maintained, domination of some individuals, groups, classes and peoples by others, in order to exploit economically, socially, culturally, politically and psychologically; (b) reactive counterviolence by dominated and exploited individuals, groups, classes and peoples, generating chain

> reaction of violent feelings, attitudes, relations, and interactions; and (c) repressive social-structural violence in response to counter violence, aimed at controlling it. (p. 30)

It is evident and compelling to recognize the systemic violence in the criminal justice system. Huddleston and Marlowe (2011) stated,

> Importantly, representation of African-Americans in jails and prisons was nearly twice that of both Drug Courts and probation, and was also substantially higher among all arrestees for drug-related offenses. On one hand, these discrepancies might be explained by relevant differences in the populations. For example, minority arrestees might be more likely to have the types of prior convictions that could exclude them from eligibility for Drug Courts or probation. On the other hand, systemic differences in plea-bargaining, charging or sentencing practices might be having the practical effect of denying Drug Court and other community-based dispositions to otherwise needy and eligible minority citizens. Further research is needed to determine whether racial or ethnic minority citizens are being denied the opportunity for Drug Court for reasons that may be unrelated to their legitimate clinical needs or legal eligibility. (p. 29)

Gil (2001) conveyed relative to the above stated process, violent acts may occur of commission and omission, “as well as socially established institutional realities, that inhibit the development of individuals, groups, classes, and entire peoples by obstructing the fulfillment of inherent human needs and the unfolding of innate human potential (p. 30). Just as violent acts are so brutally constructed in the criminal justice system, the interrelationship exists in the health care system, with the black male impacted in every area.

Educational Attainment, Institutional, Structural and Systemic Violence for a Historically and Socially Oppressed People

Historically, obtaining an education in the United States of America has been tumultuous, elusive and anti-climatic for certain marginalized groups. W.E.B Dubois in 1901 signified the adversarial and controversial posture of educational achievement and attainment indicating “education had had, and always will have, an element of danger and revolution, of dissatisfaction and discontent” (p. 27). Mydral (1944) conveyed a justification of the belief of inferiority during the era positing the unintelligibility of the Negro relative to the physical structure of the anatomy of the cranial structure and the capacity for altered reasoning ability, which allowed for discrimination in education. Mydral (1944) stated,

> The Negro’s presumed lower intelligence and the belief that the mind of the Negro cannot be improved beyond a given level have always been main arguments for discrimination in education, and, specifically, for directing Negro education toward developing his hands and not his brains. The beliefs that Negroes have a much smaller cranial capacity and lower brain weight, a less complicated brain structure, thicker skull bones, an earlier closing of the cranial sutures, have a function to explain and fortify the beliefs in the lesser development of the Negro’s higher brain centers and, consequently, his lower intelligence and reasoning power. (p. 107)

The racial climate of the country before the *Brown v. Board of Education*, of Topeka Kansas (1954), relative to the education of blacks was marked with inequalities, substandard pay for Black teachers, deteriorating facilities and inadequate funding of resources for children of color. The Supreme Court ruling in *Brown v. Board of Education* proved to be only one step in a long, difficult and evasive journey toward a gesture to bring equality to the nation’s schools particularly to benefit people of color (Zirkel, (2005). The elusiveness and unfilled prophecy of Brown and the nuances thereof remain problematic for people of color and the poor today.

More than fifty years later, conundrums associated with educational disparity since Brown have not resolved. The gravity of securing a quality education with sound pedagogical principles and fiscal unassailable secure schools remain elusive, resulting in the academic demise of many socially deprived students.

A compelling and disheartening reality is evident fifty years after *Brown v. Board of Education* in the American Public School system. Many schools, specifically those which are inner city and rural areas are just as segregated now, as was before *Brown*, with a paucity of human and material resources inclusive of meager tax dollars, non-qualified teachers, run down school buildings, a watered down curriculum and are technologically poor and/or bankrupt. According to Vocino (2010),

> Widespread income inequality in Alabama is nothing new, and the state has always ranked as one of the poorest in the country. This economy manifested itself in part as a consequence of the Civil War and some of the worst social and economic policies in the country that came about after the war. Jim Crow laws left a devastating impact on the African-American population in the state, one that can still be evidenced today. (pp. 7–8)

Complex and confounding issues relative to school resegregation and the inequalities of education finance perplex America’s present day public education system. Continuous resegregation has assumed a level not seen since the late 1950s through the late 1980s when the move toward desegregation occurred. In essence, in the Northeast and Midwest, more than 25 percent of Black students attend schools labeled as Apartheid schools. Apartheid schools assume a population of 90 to 100 percent of non-White students. Segregationist academies (Seg Academies) are prevalent in Alabama's private school system. Statistics reveal that in America, resegregation has been continuous in the last 12 years (Kozol, 2006; Orfield & Lee 2005; Tatum, 2007). Carter G. Woodson wrote 'The Miseducation of the Negro' in 1933 criticizing the modern "education system for simultaneously meeting the needs of those who enslaved while perpetuating the oppression of those who were slaves" (King, 1991, p. 428). It is widely known that the state of Alabama has a legacy of treatment to the "other" in negativistic devaluations. On January 14, 1963, the inaugural address by Governor George Corley Wallace conveyed the paradigmatic mindset of many dominant Alabamians effecting the epochal period. Wallace (1963) conveyed,

> It is very appropriate then that from this Cradle of the Confederacy, this very Heart of the Great Anglo-Saxon Southland, that today we sound the drum for freedom as have our generations of forebears before us done, time and time again through history. Let us rise to the call of freedom-loving blood that is in us and send our answer to the tyranny that clanks its chains upon the South. In the name of the greatest people that have ever trod this earth, I draw the line in the dust and toss the gauntlet before the feet of tyranny ... and I say ... segregation today ... segregation tomorrow ... segregation forever.
>
> (Inaugural address of Governor George C. Wallace of Alabama, January 14, 1963)

The paradigmatic thought in 1963 as reflected in the inaugural address of George Corley Wallace in the state of Alabama is indicative of a philosophy of segregationist demagoguery. White supremacy was the ideology of which Wallace evoked the tyrannous principles prior to and after *Brown et al. v. Board of Education of Topeka et al* (Brown v Board) became law. The Brown decision was handed down in a unanimous decision;

segregation of public schools was unconstitutional. There were five cases dealing with segregation in violation of the Fourteenth Amendment. The National Association for the Advancement of Colored People (NAACP) argued four cases before the U.S. Supreme Court: *Briggs v. Elliott et al., Davis et al. v. County School Board of Prince Edward County, Gebhart et al. v. Benton,* and *Bolling v. Sharpe.*

Wallace, elected in 1962 with the largest popular vote in the land of Dixie was successful in campaigning on issues of school anti-integrationist principles, and maintaining the separate but equal now de facto law of *Plessy v Ferguson* which was de jure prior to the passage of Brown v. Board. The overall philosophy of keeping “them” from “us” bore actualization when Governor Wallace stood in front of a schoolhouse door to prevent Black children from entering a White school and on the steps of the University of Alabama with state troopers who blocked entry of two Black students which was reflective of the content of thought of a hegemonic paradigmatic Deep South the heart of Dixie and the systemic, systematic and institutional separatist structures inclusive of the educational system, which have endured in the state in many instances. Wallace defied laws of the land, opposing the federal government and the advancement of Black Americans. The angst against the requirement of the law and the loosely interpreted decision was utilized to prevent the inevitable. According to Byrd and Clayton (2000), “The south systematically, and more or less successfully, resisted court ordered integration of public schools for more than 20 years after the 1954 Supreme Court desegregation ruling” (p. 136). While de jure segregation was not the law of the land, post the Brown v Board 1954 ruling, many Southern states, embraced the sentiment and philosophy of Governor George Corley Wallace.

According to Kusimo (1999),

The Brown decision abolished the laws ‘requiring’ segregated schools in 17 states and the laws permitting segregated schools in four other states. The Supreme Court did not outlaw de facto segregation typically found in cities outside of the South. Following the decision, school desegregation was not uniformly implemented. While many communities in border states began the process almost immediately, the eight states of the Deep South (AL, FL, GA, LA, MS, NC, SC, and VA), where Blacks constituted 22% or more of the population, did not integrate until the mid 1960s, when they were pushed by the courts (White, 1994).

In Macon County, Alabama, *Lee v. Macon* was the decision which capitulated the dual education system in Alabama which is still present today. Attorney F. D. Gray was the lead counsel of which the Plaintiffs asked the United States District Court for the Middle District of Alabama,

> to enjoin the defendants and each of them from continuing their policy, practice, custom and usage of maintaining and operating a compulsory biracial school system in Macon County, Alabama, and from the assignment of students, teachers and other school personnel on the basis of race. This case is a typical class action, seeking the desegregation of the public school system maintained and operated by these defendants in Macon County, Alabama. (Lee v. Macon County Board of Education, 267 F. Supp. 458 - Dist. Court, MD Alabama 1967, p. 1)

According to Lee v. Macon County Board of Education, 267 F. Supp. 458 - Dist. Court, MD Alabama 1967,

> After an oral hearing, a review of the evidence and arguments of counsel, this Court in July 1964 made its findings and conclusions to the effect that there was a dual school system based upon race that was maintained and operated throughout the State of Alabama and that it was the policy of the state and, in particular, the Governor, George C. Wallace, as President of the Alabama State Board of Education.… It was also concluded that Alabama's tuition grant law was nothing more than a sham established for the purpose of financing with state funds a white school system in the State of Alabama. (p. 2)

Vocino (2011) confirmed, "The current state of education in Alabama is born of the conflict and checkered past of Alabama's history" (p. 36). Segregation Academies are still present in the Black Belt south. Vocino (2011) conveyed,

> With the abolition of *de jure* segregation in1954 with the landmark *Brown vs. Board of Education* case, the country moved toward a more egalitarian society. Today the consequences of these laws are still evident, although *Brown vs. Board of Education*, the Civil Rights Act of 1964, and the Voting Rights Act of 1965 are almost distant history. (p.36)

Alabama's Public School System

A Black Belt School in the 21st Century: The Wilcox County School System

Vocino (2011), revealed a proportion of Wilcox county citizenry lack basic literacy skills, encompassing 30 percent with an unemployment rate at 20.9 percent and a poverty rate of 30.2 percent (see Figure 9). According to the Alabama Health Status Report 2011,

> There is a strong relationship between educational attainment and health status. According to the 2000 Census of Population, nearly one-third (30.3 percent) of all rural

> Alabama residents age 25 years or older had less than a high school education. This exceeds the 20.2 percent of urban residents in this age group with less than a high school education. Providing rural students with the educational opportunities to compete with urban counterparts may help in reversing the health status of rural Alabama residents. (p. iv)

Unemployment Statistics and Literacy Rate

County	Poverty Rate	Unemployment	Percentage Lacking Basic Literacy Skills
Bullock	33.6%	15.	34%
Sumter	32.9%	14.	28%
Perry	31.7%	16.	27%
Macon	30.5%	12.	25%
Greene	30.3%	19.	31%
Wilcox	30.2%	20.	30%
Dallas	29.9%	20.	24%
Hale	26.0%	11.	26%
Pickens	25.6%	10.	21%
Lowndes	25.4%	14.	28%

Figure 9. Alabama Counties in Crisis

In addition, Figure 9 makes a comparison of select Black Belt counties in the State of Alabama relative to rates of poverty, unemployment and percentages of constituents lacking basic literacy skills. As referenced by Vocino (2011), “The counties with low basic literacy skills are the ones that are poorest and most economically deprived in the state” (p. 38).

In an interview with Dr. Rosa Ashmon, Superintendent of Wilcox County Schools, one of the poorest Black Belt counties in the nation, Dr. Ashmon revealed the biggest barrier in the county was the dual school system, and limited support from much of the community. Other issues revolved around school funding, distance (students’ time traveling to, and from school affects most activities) and true parental involvement.

The racial mix of students in the Wilcox county school system supports findings from the review of literature. Dr. Ashmon confirmed, “Our schools are almost all 100% African American. The system has fewer than 10 (EA) students with poverty presenting many problems.” According to Dr. Ashmon, “Currently, all of our students eat free; however, some few would have had to pay if not for the grant; homeless programs provides school uniforms and shoes for many students.” Inadequate health care manifests as a continuing problem according to Dr. Ashmon. Confirmation was received from Dr. Ashmon that health care was a barrier in Wilcox County:

> Our funds for nurses need to increase. A nurse has to be hired for students who are prescribed certain medications with a history of seizures. Here lately many students are prescribed a medication which requires rectal administration. A nurse is required to be at a school for the administration of this medication as well as on site at all times. If students with this medication and diagnosis ride the bus, a nurse has to be available with the student on the bus. Parents have to be paid to bring the students to school with a history of seizures, because of the lack of availability of a nurse on the bus in the mornings. The funds for nurses have to come from school funds, directly from funds allocated in the budget. They need to do something to help us with this.
>
> There is a local hospital in Camden, Alabama which provides immediate access for elementary, middle and high school students in Camden, Alabama for students residing in this area. One elementary school is in Alberta the other is in Pine Hill, Alabama, 20 miles or more if they become ill while at school. If students’ become ill while home, the travel distance may be greater for many of the students. Largely, the health care that is required is addressed. Mental health/behavior issues are common.

> Having a hospital here seems okay, but most matters are referred to other facilities, which require travel. Only two doctors have offices. I think the dentist still sees patients. Other services—patients have to go elsewhere. The hospital in Thomasville closed which made the travel for people on that side of the county longer. It is rumored that another hospital in the area is scheduled to close. For mental health issues—service is largely for problems; little, if any, prevention or intervention is available.
>
> Little support is received from the community; however, the Department of Human Resources (DHR) and the school system collaborate; same for the Children's Policy Council; the Sheriff and system works well, but usually on security. There is a junior deputy group among students. I am working now with Alabama Tombigbee and with others to get ready for the new employer that is supposed to come to the area—Golden Dragon. Alabama Southern College is supposed to work with us, but so far…."

Dr. Ashmon identified other areas that need to be addressed in the community which are inclusive of:

> (a) recruitment of personnel to the system (impacted by segregated school system); (b) after school resources(largely directed to athletics only, library closes early); (c) housing; (d) travel distance; (e) few true stores; (f) shopping areas; (g) limited service providers; (h) recreational providers, etc.; (i) family structure; (j) homelessness with many homes having several "generations" and limited space.

Suitts and Veasey (2008) conveyed,

> The dilemmas of Alabama education have existed for over 140 years. Since the Civil War, the state has trailed the South and the nation in educational attainment. During the

> intervening decades, the state's educational gap with the nation has narrowed, and a handful of Alabama communities have made significant advancements. (p. 5)

Student test scores on the state and national level revealed that on average, students in Alabama's public schools overall are behind the national average when entering high school. According to Suitts and Veasey (2008), the National Assessment for Educational Progress (NAEP) revealed,

> …the average Alabama student is behind the average American student in a mastery of skills and knowledge by about 10 percentage points in reading and other subjects. This difference represents roughly a disparity of one year of knowledge and learning. These national tests also indicate that 8th grade reading scores in Alabama have steadily declined since 2003 while national scores have risen since 2005, only widening Alabama's learning gap with the nation. In 2007, Alabama ranked near the bottom in national test scores in reading and in most other basic subjects for 8th grade students. (pp.13–14)

Vocino (2011) postulated, "Poorly performing and underfunded schools have a detrimental impact on Alabama's ability to recruit new industry because many students do not have the skills to compete in today's workforce" (p. vi). Not only does the lack of a high school degree impact new industry in the state, but the dropout rate violently impacts the "Dropout" in varied contexts to obtaining a higher quality of life. For 2009–2010 academic years, the state of Alabama had a graduation rate of 87.65 percent with a dropout total of 3934 students (Alabama Department of Education). According to the Southern Poverty Law Center (2008),

> [Alabama's]… high school graduation rate has ranked … among the bottom five to ten states for the last twenty years. Meanwhile,… school discipline rates consistently rank among the highest in the country. Research [indicates] that discipline rates and dropout rates are deeply related, and that punishments like out-of-school suspension are actually counterproductive to a student's success. (p. 4)

In the 2004–2005 school year, on average, approximately 1 in 10 students in Alabama's schools were suspended, the rate for Black students averaged 17 percent higher, according to the U.S. Department of Education (Suitts & Veasey, 2008).

Suitts and Veasey (2008) further postulated, 40 percent of Alabama's high school dropout rate, is further "compounded by the 40 percent of high school graduates who do not enter college" (p. 13). Suitts and Veasey (2008) acknowledged,

> The net effect is that roughly two-thirds of Alabama's 9th grade students fall out of the education pipeline before college, where individuals and the state will realize the largest economic gains of education. Of those 9th graders in 1994 who did enter college in 1998, over 60 percent failed to graduate within 6 years. (p. 13)
>
> On average, a high school graduate in Alabama earns **$6,942** more each year than a high school dropout does. Roughly 23,000 students in Alabama did not graduate from high school in 2011; the lost lifetime earnings for that class of dropouts alone total **$2.5 billion**. If just half of Alabama's dropouts had graduated, they would likely have provided the following economic benefits to their state: (a) **$227 million** in increased home sales and **$13 million** in increased annual auto sales, (b) **800** new jobs and a **$141 million** increase in the gross state product, (c) **$6.6 million** in increased annual state tax revenue. If Alabama's high schools were to graduate all students ready for college, the

> state would likely save as much as **$80 million** in college remediation costs and lost earnings. (p. 13)

According to the SPLC (2008), the Alliance for Excellent Education estimates that Alabama's high school dropouts from the class of 2007 would have earned an additional $6.7 billion in their lifetimes had they graduated. Instead, they have a much higher risk of entering the juvenile and criminal justice systems. (p. 5)

The SPLC (2008) indicated in 2006, "Alabama had the eighth highest out-of-school suspension rate in the nation" ... with African-American students being "3.2 times as likely to be suspended as their White peers and almost 3.8 times as likely to be expelled" (p. 5). Between the school years of 2000–2001 and 2006–2007, "Alabama's school enrollment increased by 2.1 percent", "with the number of out-of-school suspensions" increasing "by 33 percent, and the number of expulsions increased by 75 percent" (SPLC, 2008, p. 5). In Alabama, "on every school day, an average of 417 out-of-school suspensions are issued, and 7 students are expelled from school" (SPLC, 2008, p. 5). The SPLC (2008) conveyed,

> [In Alabama][m]any youths end up in the juvenile justice system because of school-related misconduct—not just for violent behavior. Instead of handling relatively minor disruptive behavior through traditional, non-exclusionary discipline methods like after-school detention and extra assignments, many schools are turning to the juvenile court system. School discipline referrals clog judicial dockets in jurisdictions around the state. (p. 6)

The SCLC (2008) viewed the dropout rate as being significant to outcomes which impact financial stability in the state of Alabama. The SCLC (2008) posited,

> By reducing the number of students referred to the criminal justice system for minor in-school misbehavior, we can also reduce the number of kids who drop out—and save our state the money it needs to educate our children—without sacrificing school safety. (p. 7)

The education of African American males continues to pose challenges. The Schott Foundation (2008) posited, "The rate at which Black males are dropping out and being placed in special education far exceeds the rate at which they are graduating and reaching high levels of academic achievement" (p. 1). In 2007–2008 Alabama ranked among the lowest 10 states for graduation rates of Black males, with 42 percent meeting state requirements in comparison to 60 percent of their European American male counterparts. There were 134,533 males enrolled in Alabama's school systems. Montgomery, Alabama, a Black Belt county, had an enrollment of 12,359 Black males with 42 percent meeting requirements for graduation in comparison to 47 percent European American students (Schott Foundation, 2008). According to the Schott Foundation (2008),

> Over the last 25 years, the social, educational and economic outcomes for Black males have been more systemically devastating than the outcomes for any other racial or ethnic group or gender. Black males have consistently low educational attainment levels, are *more* chronically unemployed and underemployed, are less healthy and have access to fewer health care resources, die *much* younger, and are *many times* more likely to be sent to jail for periods *significantly longer* than males of other racial/ethnic groups. On average, Black males are more likely to attend the most segregated and least resourced public schools. (p. 3)

A recent report from the United States Department of Education (ED) Office of Civil Rights released on March 6, 2012, indicated a disparity in disciplinary procedures of Hispanic and African American males. The U.S. Department of Education (ED) Civil Rights Data Collection (CRDC) report, released March 6, 2012, found a significant disparity associated with disciplinary actions of minority students, more specifically, African American and Hispanic males. Overall, CDRC data revealed; (a) “African-American students are over 3½ times more likely to be suspended or expelled than their peers who are white”, (b)“African-American students represent 18% of students in the CRDC sample, but 35% of students suspended once, 46% of those suspended more than once, and 39% of students expelled”, (c) “over 70% of students involved in school-related arrests or referred to law enforcement are Hispanic or African-American”, (d) “in districts that reported expulsions under zero-tolerance policies, Hispanic and African-American students represent 45% of the student body, but 56% of the students expelled under such policies”, and (e) “while male and female students each represent about half the student population, males made up 74% of the students expelled”.

It is perplexing, unsettling and problematic to know that, “Being a young black man has been called the hardest job in America. Young black men are much more likely than white men to be jobless, in jail and labeled “suspicious,” sometimes with deadly consequences”(Morial, 2012, Para I). The College Board (2011) posited,

> The “endangered species” literature, particularly of the 1900s and into the early 2000s, unanimously, describes a bleak context in which African American males disproportionately experience social and economic peril—as homicide victims/perpetrators, suicide victims, HIV/AIDs sufferers; with high rates of arrest/conviction/incarceration, high infant mortality, declining life expectancy and high

> and high unemployment. This research presents a number of similarly gloomy educational outcomes for African American males: high rates of suspension, expulsion and grade retention; low graduation rates; over presentation in special education; and disengagement. (p. 22)

Livingston and Nahimana (2006) conveyed,

> Educating young African American males has become an increasing concern for educators and human service professionals over the past 20 years. Disproportionate rates of school failure drop out, and incarceration all speak to a need to develop interventions, which can account for the structural and ecological factors that impact Black families and Black children. (p. 209)

The nuances associated thereof, in realizing educational achievement and attainment in K–12 and higher education has evoked a society of people, those marginalized and of minority status, who aren't prepared or qualified to compete in the global workplace. Such failurism and lack of achievement of those marginalized individuals in comparison to dominant members of society has promoted and sustained standards of living which are substandard. Perpetual and cyclic distinctions, of those ill equipped to maneuver soundly through the labyrinth to obtain educational success, the liberty and totality indicative of such, are associated with and display attitudes and spirits of defeatism, which are toxic, often generational, noting a lack of wholeness and completeness in educational achievement and attainment.

Educational Deficits of Black Males

According to the Schott Foundation (2010), "only 47% of Black males graduate from high school" (p. 3). "The rate at which Black males are dropping out and being placed in special education far exceeds the rate at which they are graduating and reaching high levels of academic achievement" (Schott Foundation, 2008, p. 1). According to the Schott Foundation (2010), nationally, "…more than four times as many White male students take Advanced Placement Mathematics and Science classes as Black male students" (p. 37). The Schott Foundation (2010) conveyed,

> …[A] Black male student who manages to achieve high school graduation speaks more for that individual's ability than for benefits he may have received from the system. …the data indicates that most systems contribute to the conditions in which Black males have nearly as great a chance of being incarcerated as graduating. (Schott Foundation, p. 4)

The Schott Foundation(2010) indicated, according to the National Assessment of Educational Progress (NAEP; 2009) on eighth grading reading percentages, in Alabama, only 6 percent of Black Males were proficient compared to 28 percent of their White male counterparts. The Schott Foundation (2010), asserted,

> More than twice as many Black male students as White male students receive out of school suspensions and three times as many Black male students as White male students are expelled. Out-of-school suspensions in many cases lead to students ending their school careers before graduation. These school discipline disparities may account for a significant portion of the Black male students who do not graduate with their cohort. (p. 35)

According to the Schott Foundation 2010,

> …Black male students are not given the same opportunities to participate in classes offering enriched educational offerings. They are more frequently inappropriately removed from the general education classroom due to misclassifications by Special

> Education policies and practices. They are punished more severely for the same infractions as their White peers. On average, more than twice as many White male students are given the extra resources of gifted and talented programs by their schools as Black male students. Advanced Placement classes enroll only token numbers of Black male students, despite The College Board urging that schools open these classes to all who may benefit. In districts with selective, college-preparatory high schools, it is not uncommon to find virtually no Black male students in those schools. Finally, the national percentage of Black male students enrolled at each stage of schooling declines from middle school through graduate degree programs. (p. 4)

It has been documented that disadvantaged students have fewer resources than their more advantaged counterparts. The Schott Foundation (2010) posited,

> As Linda Darling-Hammond has noted, schools and districts that have the highest percentages of disadvantaged students tend to have the least access to the resources needed for all students to succeed. Thus, White males in schools and districts with large percentages of Black male students are also likely to experience poor outcomes because of systemic decisions not to commit resources to those districts and schools.
> (p.8)

This chapter provided an overview of the literature which supported the conceptual and theoretical frameworks for an exploration of trust in the health care system, perceived hope to the quality of life satisfaction for the legacy of victims of a study, the USPHS Study of Untreated Syphilis in the Negro Male, entrenched in an epochal period of injustice and unfairness, with the legacy of a sentinel event spanning generations with continuous historical rhetoric of mistrust in a health care system, denoting health care disparities and inequities in all aspects of social life for a minority people with a history of chattel slavery.

Review of Empirical Studies

The Scientific Information Stream of the USPHS Tuskegee Study of Untreated Syphilis

Katz (2011) provided a concrete time line which situates an “Information Stream from 1972–2010 which created—and then assessed—the ‘Legacy of the USPHS Syphilis Study at Tuskegee’” (p. xxiv–xxvii). Katz (2011) characterized the Scientific Inquiry Period for the USPHS Syphilis Study for the Untreated Negro Male from 1997–2010. During this time period the following qualitative studies were conducted: (a) Corbie Smith et al., 1999; (b) Green et al., 2000; (c) Freimuth et al., 2001; and (d) Bates and Harris, 2004. Quantitative studies during the time era were inclusive of: (a) Green et al., 1997; (b) Sengupta et al., 2000; (c) Shavers et al., 2000; and (d) Brown and Topcu, 2003. Fouard et al. and Wendler et al. were included in the inquiry during the years of 2004 and 2006 respectively. The Tuskegee Legacy Project (TLP) occurred by Katz et al. in: 2006 (on willingness), 2008a (“on ‘legacy’”), and 2008b (“on apology effect”). The City TLP studies conducted by Katz et al. in 2007 (“willingness validation”), 2008 (perceptions of risk), 2008c (“‘legacy’ validation”), and identifying the Tuskegee Syphilis Study (2009). In “Examining Tuskegee: The Infamous Syphilis Study and Its Legacy”, Riverby (2009) examines the consequences and aftermath of the study from varied perspectives. Documents related to the Guatemala military prisoners were uncovered by Riverby (2009) through a continuing historical archival research of the USPHS Tuskegee Study. The unethical study in Guatemala occurred in the 1940s under the auspices of the USPHS with one of the lead-physician investigators of the USPHS Study of Untreated Syphilis in the Negro Male. The Guatemala Study encompassed varied methods of infecting prisoners with syphilis with an overarching premise to test if antibiotics would prevent infection from occurring in the prison population.

Katz (2011) stated prior to 1997, there were not any published data-based research driven articles on biomedical studies which directly examined participation in differential comparison of dominant members to Black Americans or other minorities due to awareness of the USPHS Study of Untreated Syphilis in the Negro Male. Eight data-based research articles assessed either specific or general awareness and "self-reported willingness to participate in biomedical research" were published between 1997 and 2004. (p. xxxii).

Katz (2011) asserted that two overarching questions which seek to assess the "validity of the widely held "legacy" associated" with the syphilis study which encompassed the reluctance of Black Americans to participate in biomedical research because of an awareness of the USPHS Study of Untreated Syphilis in the Negro Male. The two questions according to Katz (2011) are: (1) What is the evidence that blacks are less willing to participate in biomedical research studies as compared to whites? and (2) "Is willingness to participate in biomedical research studies directly associated with awareness of the USPHS Syphilis Study at Tuskegee?" In a summary of the evidence from the Scientific Period of Inquiry which occurred from 1997–2010, Katz (2011) clarified,

> …both the eight exploratory studies and the nine later definitive studies—convincing and uniformly lead to the conclusions that: (1) blacks are equally as willing as whites to participate in biomedical research, and (2) there is no association today between an awareness of the USPHS Syphilis Study at Tuskegee and willingness to participate in biomedical studies, for either blacks or whites. The early clues were detected relatively

> consistently in those eight early studies, with definitive findings then provided, again consistently, across the seven later studies of the scientific inquiry period. (p. xxxvi)

Katz (2011) further asserted,

> This so called legacy allows scientific researchers and potential research subjects to move forward toward the necessary and legitimate goal of realizing diverse samples of subjects in biomedical studies. Moreover, this clarification encourages further exploration of what precisely is the legacy of the USHPS Syphilis Study at Tuskegee. (p. xxxviii)

Mistrust Literature

Trust literature incorporates the necessity of a physician –patient relationship grounded in the essence of confidence, hope and faith. The concept of trust is central to the successful survival of a physician patient relationship. Hall, Dugan, Zheng and Mishra (2011) conveyed, “[trust is the core, defining characteristic that gives the doctor-patient relationship meaning, importance, and substance” (p. 613). Numerous empirical studies have documented a lack of trust in physician/patient relationships.

LaVeist, Nickerson, and Bowie (2000) conducted a study of patients diagnosed with chronic heart disease. The sample population included 1003 Northern European Americans and 781 Black American patients who had frequent visits to a physician. Survey questions incorporated the perception of overall satisfaction with care from the physician, inherent racial bias in the health care system, and perceived trust of the provider of care. Through multivariate analysis, the following demographics were measured: (a) educational level, (b) type of insurance, (c) age, (d) race, and (e) gender. An analysis of the data revealed which of the afore-referenced variables were related to satisfaction of care. According to the results, Black

Americans were significantly less satisfied with the level of care received than Northern European Americans. When all measured variables were reviewed, a relationship existed between age, physician trust, racial bias, and patient satisfaction.

Further analysis revealed the higher the level of satisfaction, the higher the level of trust. Lower levels of satisfaction were correlated with perceived racial bias. When measures of perceived bias and trust were included in the analysis, race was not deemed significant with satisfaction. Results revealed Black Americans approached the patient –physician encounter with higher levels of perceived bias and lower levels of trust. Other findings revealed a perception of trust and bias were strongly associated more strongly independent of race.

A final analysis included a review of patients who were referred for cardiac catheterization. Results revealed study participants with higher levels of trust in the health care system were most often referred for cardiac catheterization. In essence, Black Americans were referred less for cardiac catheterization than their Northern European American counterparts.

Pieterse and Carter (2007),

> … explored the relationship among general life stress, racism-related stress, and psychological health in a sample of 220 Black men. Participants completed a personal data form, the Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983), a modified version of the Schedule of Racist Events (Landrine & Klonoff, 1996), and the Mental Health Inventory (Veit & Ware, 1983). Results of hierarchical regressions indicated that when general stress was controlled, racism-related stress predicted an additional 4% of variance in psychological distress for working class men and an additional 7% for middle–upper class men. Racism-related stress also predicted an additional 5% of variance in psychological well-being for middle–upper class men;

> however, it was not predictive of psychological well-being for working class men. (p. 101)

Shavers, Lynch, and Burmeister (2002) reported, during 1998–1999, participates were solicited for a survey in the Detroit Primary Metropolitan Statistical Area (PMSA) that examined barriers inhibiting participation in medical research studies. "Chi square tests and logistic regression analyses were used to examine the association between race, issues related to trust of medical researchers, and the willingness to participate in medical research studies" (p. 248). Respondents overall were willing to participate in medical research studies if they were Northern European Americans, under age 65, female and had graduated from high school or had more education. Educational level was statistically significant. Approximately 51 percent of Black Americans stated that knowledge of the Tuskegee Syphilis Study encompassed feelings of having less trust in researchers, with 48 percent reporting that there was change in trust levels, 1 percent of participants reported that more trust occurred. In comparison, 17 percent of white respondents had knowledge of the Tuskegee Study, with 17 percent reporting that less trust occurred in medical researchers. Eighty-three percent reported having had no change in trust levels with none reporting more trust in researchers. The alpha for this study was set at $p = 0.02$). In essence, according to Shavers, Lynch, and Burmeister (2002),

> Study results indicate that African Americans and whites differ in their willingness to participate in medical research. Racial differences in the willingness to participate in medical research are primarily due to the lower level of trust of medical research among African Americans. African American respondents were also somewhat less willing to participate if they attribute high importance to the race of the doctor when seeking

> routine medical care, believed that minorities bear most of the risks of medical research, and their knowledge of the Tuskegee Study resulted in less trust in medical researchers. These data reiterate the need for medical researchers to build trusting relationships with minority communities. Researchers can begin by acknowledging the previous medical abuse of minority research participants, discussing their specific plans to assure the protection of study participants, and explaining the need for the participation of racial/ethnic minorities including studies that specifically target or that are likely to result in disproportionate representation of racial/ethnic minorities among study participants. (p. 248)

Wendler et al. (2006) conducted a comprehensive review of the literature in an effort to identify all published studies pertinent to health research which reported rates of consent by race or ethnicity. Wendler et al. (2006) found 20 such studies supporting the identified parameters. The 20 studies reported on the decision to enroll over 70,000 individuals for varied areas of research, ranging from interviews to drug treatment, as well surgical trials. From the 20 studies reviewed eighteen were single-site studies conducted in the US. Multi-site studies were conducted primarily in the US. Two studies were conducted abroad. According to Wendler et al. (2006),

> …small differences in the willingness of minorities, most of whom were African-Americans and Hispanics in the US, to participate in health research compared to non-Hispanic whites. These findings, based on the research enrollment decisions of over 70,000 individuals, the vast majority from the US, suggest that racial and ethnic minorities in the US are as willing as non-Hispanic whites to participate in health research. Hence, efforts to increase minority participation in health research should

> focus on ensuring access to health research for all groups, rather than changing minority attitudes. (p.0201)

According to the DHHS (2001),

> A recent survey conducted for the Kaiser Family Foundation (Brown et al., 1999) found that 12 percent of African Americans and 15 percent of Latinos, in comparison with 1 percent of whites, felt that a doctor or health provider judged them unfairly or treated them with disrespect because of their race or ethnic background. Even stronger ethnic differences were reported in the Commonwealth Fund Minority Health Survey: It found that 43 percent of African Americans and 28 percent of Latinos, in comparison with 5 percent of whites, felt that a health care provider treated them badly because of their race or ethnic background. (p. 29)

CHAPTER III: METHODS

It is a difficult thing to admit to wrong doing—especially when it consists not just of a single heinous act but rather of years and decades of continuing heinous acts that involved faulty decisions of hundreds of people. Nevertheless, we must admit to gross wrongdoing in order to make amends for the past. We must also admit these heinous acts to those generations who come after us so that this kind of horror will never happen again.

M. Joycelyn Elders (2011)

Introduction

The purpose of this study was to collect information related to the level of medical mistrust and underutilization of healthcare consumers in the health care system; the level of perceived hope to the quality of life satisfaction of adults ages 19 and above living in Alabama's extended Black Belt counties. This study identified levels of medical mistrust, and the levels of perceived hope and quality of life satisfaction of adults residing in Alabama's Black Belt counties. According to LaVeist, Isaac and Williams (2009), there is a "lack of empirical research on mistrust in medical care settings and its impact on utilization of health services" (p. 2093).

Based on the theoretical framework of the Trust, Hope and Quality of Life Interrelationship Determinants Model the following research questions were derived:

1. What is the level of Trust in the Healthcare System?

2. What is the level of perceived Hope to Quality of Life Satisfaction?

3. What is the quality of life satisfaction as measured by the Endicott Short Form General Activities subscale of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q- LES-Q)?

4. What is the relationship of Trust in the Health Care system and perceived hope to the Quality of Life Satisfaction among adults in Alabama's Expanded Black Belt?

The study is framed with two independent variables (Trust and Hope) and one dependent variable (Quality of Life Satisfaction) substantially assessing the levels of and Hope and the level of Quality of Life Satisfaction. Chapter IV will describe the research design, the sample selection, description of the sample, data collection, protection of human subjects, instrumentation, data coding and statistical analysis.

Design of the Study

A correlational design using a survey approach with a convenience sample was used to answer the research questions. The study variables trust, perceived hope and quality of life satisfaction were drawn from the Trust, Hope and Quality of Life Interrelationship Determinants Model (see Figure 1) which were deductively derived from the literature. Regression analysis and Pearson correlation were used to answer the research questions relative to the strength and direction of the relationships between trust, perceived hope and the quality of life satisfaction of adults ages 19 and over participating in the study. The SAS statistical analysis program was used to analyze the data in this study.

Validity in Quantitative Methodology

The most critical step in test development and use is validation, the process which derives meaning and interpretation from scores (Benson 1998; Cronbach 1971; Messick, 1989).

Terms which are aligned with the process of validity include: (a) scale, (b) measure, (c) instrument, and (d) inventory with a reference to measurements that are cognitive as well as affective (Benson, 1998). The process is continuous to ensure validity over time, given: (a) changes in traits, (b) varied cultural and social conditions, (c) differing samples and populations, and (d) varied approaches (Benson, 1998). Polit and Beck (2004) clarified, "Validity is …a complex concept that broadly concerns the soundness of the study's evidence—that is whether the findings are cogent, convincing and well grounded" (p. 36). In essence, Rubio, Berg-Weber, Tebb, Lee and Rauch (2003) typically referenced validity types as: (a) construct, (b) criterion, and (c) content.

Construct Validity in Quantitative Methodology

Complex constructs are studied by researchers in the social sciences, thereby, measures which are reliable and valid are necessary (Rubio et al., 2003). A construct is representative of a variable which is derived from a theory or observation (Benson, 1998). According to Cronbach and Meehl (1955), a construct is an, "attribute of people assumed to be reflected in test performance" (p. 288).

An interpretation will be derived from the established attribute (Benson, 1998). In this study, attributes from which inference was drawn were from instruments assessing the levels of medical mistrust, hopefulness, hopelessness and quality of life satisfaction as measured by the LaVeist Medical Mistrust Index V2.2, the Hendricks/Murdaugh/ Hendricks Hope Scale (H2MHS) and Endicott's Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). The process in which meaning is derived from test scores, through validation of constructs, is much similar to the development of scientific theoretical approaches. A nomological network references relationships from a foci construct and other constructs (Beeson, 1998; Cronbach & Meehl, 1955).

The generation and testing of hypotheses involving the construct within the nomological network and rival hypothesis is continuous, in attempts to clarify observed behavior. The testing of hypothesis occurs in isolation in verifying conclusions. Conclusions which are drawn might possibly require: (a) additional observances of behavior, (b) varied interpretation of former research, (c) a need for theoretical revisions, (d) warrant additional hypothesis, and (e) provide support for the derived theory. The process of construct validity is iterative; a constant evaluation and refinement of the theory and test is in occurrence (Beeson, 1998).

Content Validity

Rubio et al. (2003) stated, “Content validity refers to the extent to which the items on a measure assess the same content or how well the content material was sampled in the measure” (p. 94). Face validity or logical validity can be referenced as content validity. When refereeing to face validity, indications relate to the appearance of the items, in principle “on its face” (Rubio et al., 2003, p. 94). In essence, appearances are that the instrument is measuring the concept as intended (LoBiondo-Wood & Haber, 2002). In comparison, logical validity denotes a stricter process. A panel of experts could be employed to evaluate or assess the “content validity of a measure” (Rubio et al., 2003, p. 94).

However, Polit, Beck and Hungler (2001) related that a content validity index which indicates the magnitude of agreement from the experts can be calculated; however, ultimately subjective opinions from the experts must be adhered to and followed. According to Polit, Beck and Hungler (2001), “the content validity of an instrument is necessarily based on judgment. There are no totally objective methods for ensuring the adequate content coverage of an instrument” (p. 309).

Criterion Validity

Polit, Beck and Hungler (2001) stated criterion-related validity relates to the correlation of scores on an instrument with an external criterion. Moss (1995) stated, “There is a close to universal consensus among validity theorists” that “content- and criterion-related evidence of validity are simply two of many types of evidence that support construct validity” (p. 6).

According to Adcock and Collier (2001), **“**criterion validity assesses whether the scores produced by an indicator are empirically associated with scores for other variables, called criterion variables, which are considered direct measures of the phenomenon of concern” (p. 537). LoBiondo-Wood and Haber (2002) further clarified criterion-related validity as to the degree the performance of the subject’s performance on a tool of measurement and actual behavior share a relationship or commonalities. According to LoBiondo-Wood and Haber (2002), the second measure is usually the criterion, “which assesses the same concept under study” (p. 339). Concurrent validity relates to two measures and the degree of correlation measured within the same period of time. If a high correlation exists between the two measures, an indication is that agreement exists. In comparison, predictive validity, relates to an agreement or degree of correlation between the concept measured and the concept measured in a future period of time. LoBiondo-Wood and Haber (2002) conveyed with the passage of time, predictive validity is likely to be lower.

Reliability in Quantitative Methodology

According to Polit, Beck and Hungler (2001), for a quantitative measure, a major criterion is to assess reliability. Overall, the essence of reliability is simply the consistency and accuracy of an instrument which holds true over time in attribute measurement. Repeated measures of the instrument yield the same results (LoBiondo-Wood & Haber, 2006). A measure is denoted to be reliable if the error of a score is minimized and the true score component is maximized. Researchers primarily embrace three aspects of reliability inclusive of: (a) internal consistency, (b) stability, and (c) equivalence. Interestingly, Polit, Beck and Hungler (2001) add two other dimensions of reliability: precision and homogeneity. Precision is reflective of consistency or reproducibility accuracy of measurement tools (Burns & Groove, 2003). Stability attests to the test-retest component of reliability, which implies that on two occasions, a researcher administers the same measure to the same population sample and compares the scores. To assess internal consistency, the same instrument is used each time the population is sampled (Polit, Beck & Hungler, 2001).

Stability stipulates that with each use or testing time frame, the instrument produces the same results. Homogeneity indicates that the same concept is measured by each item on the instrument. It is important that when multiple or parallel instruments are administered or procedures are used, the same results are produced which equates to equivalence. LoBiondo-Wood and Haber (2006) stated that there are varied tests of reliability which are commonly used and are inclusive of: (a) Cronbach's alpha, (b) interrater reliability, (c) Kuder Richardson (KR-20), (d) test-retest, (e) parallel or alternate form, (f) split-half, and (g) item-total correlation. The following tests fall within the stated areas: (a) stability (i.e. test-retest reliability and parallel or alternate form), (b) homogeneity (i.e. item to total correlation, split-half reliability, KR-20, Cronbach's alpha), and (c) equivalence (i.e. parallel or alternate form, interrater reliability). The Cronbach's alpha is used most commonly to determine internal consistency (LoBiondo-Wood & Haber, 2006).

Sample Selection

A convenience sample of 310 adults ages 19 and above from a faith-based community and residing in Alabama's extended Black Belt counties were used. To increase heterogeneity within the sample, participants were used from various locations, cities and towns in Alabama's expanded Black Belt counties from Southeast Alabama in faith-based communities.   An Information Letter (see Appendix A) was provided with IRB information. Criteria for inclusion in this study included:

1. Residing in a Alabama Black Belt county in Alabama
2. Being at least 19 years or older
3. Being a part of a faith based community
4. Willingness to participate in the research and respond to the questionnaire.

Data Collection Procedure

A convenience sample of 310 participants from faith-based communities in Alabama's Extended Black Belt Counties was used to complete a four-part survey (see Appendix B). Institutional Review Board (IRB) approval was received for the study (see Appendix C). Consent was obtained to utilize survey instruments by Dr. Thomas LaVeist (see Appendix D), Dr. Constance Hendricks (see Appendix E), and Dr. Jean Endicott (see Appendix F). An informational letter was sent to the District President in the Southeast District. Consent was obtained from Dr. C.P. Noble, District President, to survey members of the Southeast District (see Appendix G). Participants were recruited for the project using printed announcements in church newsletters, bulletins, flyers on bulletin boards, and letters to the congregations, denoting inclusion/exclusion criteria (see Appendix H); and verbal announcements at church functions as permitted. One week after the second recruitment announcement, the Principal

Investigator (PI) went to the designated church to provide study information and answer questions following the conclusion of the Sunday morning service and meet with potential participants. Verbal consent was given by members after reviewing IRB Informational Letter criteria (see Appendix A). Self-report on inclusion and exclusion criteria was stated in the recruitment flyer to the congregation (see Appendix H). Implied consent was substantiated by participants volunteering to participate in the study. Informational letters with Institutional Review Board (IRB) information was provided to the participants (see Appendix A).

The PI was stationed in a designated area with tables and chairs as participants entered the area after hearing the verbal public announcements or reading flyers recruiting volunteers. The PI reviewed the information letter, research study purpose, and answered any questions from the participants. A copy of the information letter (Appendix A) and was provided to each person. Those verbally consenting to participate were given the survey to complete.

At the Enterprise Convention Center, Dr. C.P. Nobel provided a verbal public announcement relative to the research study. The PI read the approved printed Verbal Announcement (see Appendix I) and provided participants with information letters with IRB information and answered questions. The four-part survey (see Appendix B) was distributed to consenting participants at the designated area. The protocol previously discussed was followed.

The responses from the survey participants were requested as anonymous with no identifiers. At assigned time periods, the PI met with individuals who volunteered to participate in the study. Packets were distributed with survey instruments. Individuals completed the information without coercion. Incentives were provided once the participant returned the survey packet and included a $5.00 gift card (see Appendix J), a bottle of water, and a participation certificate (see Appendix K).

Protection of Human Participants

The purpose and procedures of this study were explained through written instructions. The proposal, the Information Letter (see Appendix A) and the instruments (see Appendix B) were reviewed by the investigator's dissertation committee and Auburn University's IRB. Each participant was given an information letter. The information letter emphasized the voluntary nature of participation and the freedom to withdraw from the study at any time without penalty. The information letter also provided benefits of involvement, which were a Certificate of Appreciation (see Appendix K), a $5.00 gift card (see Appendix J) and a bottle of water.

Instrumentation

A four-part questionnaire (see Appendix B) was used to collect the data. The four-part questionnaire included a sociodemographic form and three instruments to collect data on the predictor outcome of the variables (see Appendix B). The instruments used in this study were the LaVeist Medical Mistrust Index V2.2 (MMI) Measuring Mistrust, and the Hendricks/ Murdaugh/Hendricks Hope Scale (H2MHS) to measure perceived level of hopefulness and hopelessness, and Endicott's Quality of Life Enjoyment and Satisfaction Questionnaire (see Appendix B) to measure life enjoyment and satisfaction.

Medical Mistrust Index V2.2 (MMI) Measuring Mistrust in Healthcare Utilization

The MMI is a seven item scale with a single dimension developed by Dr. Thomas LaVeist, that uses a four-point Likert format to measure response frequencies ("Strongly Disagree" = 1, "Disagree" = 2, "Agree" = 3, "Strongly Agree" = 4). Test-retest reliability ranged from a Pearson correlation of 0.346–0.697. In multivariate modeling, a prediction of the MMI on four of five measures reporting underutilization of associated health care services. The seven item MMI loaded above 0.5. The computed reliability coefficient (Cronbach's alpha) was 0.76. The MMI in multivariate modeling was predictive on four of five measures of health services underutilization: medical advice failure (b = 1.56, p = .01), failure in keeping follow-up appointments (b = 1.11, p = .01), postponing receiving needed care (b = 0.939, p = .01) and failure to fill a prescription (b = 1.48, p = .002). With a failure to get medical care the MMI was not significant (b = 0.815, p = .06). In underutilization of health care services, the MMI proved to be a robust predictor. The MMI is useful in patient and community studies and measures the "relationship between mistrust and race disparities in health services" (LaVeist, Isaac & Williams, 2009, p. 2093).

Hendricks/Murdaugh/Hendricks Hope Scale (H2MHS)

Hendricks, Murdaugh and Hendricks (2000) developed the H2MHS to measure perceived levels of hope (positive and negative). The H2HMS is a 22-item scale that uses a four-point Likert format to measure response frequencies ("disagree a lot" = 1, "disagree a little" = 2, "agree a little" = 3, "agree a lot" = 4). The possible range of scores is 22 to 88, or 1 to 4 if using the mean of the values assigned based on the four-point scale. There are two subscales: Hopefulness (positive hope) and Hopelessness (negative Hope). For the Hopefulness subscale (positive hope), higher scores indicate higher perceived levels of hope (n = 13 items). For the Hopelessness subscale (negative Hope), higher scores indicate higher perceived levels of negative Hope. (n = 9 items). In either subscale, a mean score between 4 and 3 is considered high, between 3 and 2 is considered moderate, and mean score between 2 and 1 is considered low. The reliability for the total Hope instrument is 0.94 as measured by

Cronbach's alpha; 0.90 for positive Hope subscale and 0.94 for the negative Hope subscale. The reading level for this tool is grade 4.9. (Hendricks, Hendricks, Murdaugh et al., 2005).

Endicott's Quality of Life Enjoyment and Satisfaction Questionnaire

The General Activities subscale of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) was developed by Dr. Jean Endicott and is derived from the longer self-report 93 item form. The Short Form of the Q-LES-Q, while a subscale of the larger instrument is highly correlated with each subscale which evokes legitimacy of its separateness as an individual questionnaire. The Short Form is comprised of 16 items which cover a range of issues of life; the two global items numbers 15 and 16 of the 16 item survey are not included in the scores which measure medication satisfaction and contentment with overall life satisfaction. The Quality of Life Enjoyment and Satisfaction Questionnaire is widely used with patients when measuring life satisfaction during both pre and post treatment therapy phases (Schechter, Endicott & Nee, 2007, p. 45). The Q-LES-Q Short Form uses a five-point Likert format to measure response frequencies ("very poor" = 1, "poor" = 2, "fair" = 3, "good" = 4 and "very good" = 5). A self-report is provided and rated over the degree of enjoyment experienced during the past week. A percentage is derived from the calculation of the total scores of items 1 to 14. The possible range of scores is 14 to 70. Higher scores are indicative of having a greater enjoyment or life satisfaction. "Raw summary scores are expressed as a percentage of the maximum possible score to facilitate comparisons across areas of functioning" (Schechter, Endicott & Nee, 2007, p. 47). The minimum score is 1 for a given item instead of 0. The maximum percentage score is calculated as: "(Raw Score-Minimum Possible Score) (Maximum Possible Score – Minimum Possible Score)" (Schechter, Endicott & Nee, 2007, p. 47). Some principal investigators report their data relative to "raw mean scores, while others calculate the maximum percentage score as a percentage of 70" (Schechter, Endicott & Nee, 2007, p. 47). The Short Form of the Q-LES-Q is found to be highly valid and reliable scale (Bondareff et al., 2000; Brady et al., 2000; Endicott et al., 1993; Pearlstein et al., 2000; Pohl et al., 1998; and Endicott et al., 2006). In a community sample, with short term use of 1 to 2 weeks, test-retest reliability of the 14 item total score was 0.86, with an overall rating of test-retest consistency of life satisfaction and content of 0.71. The internal consistency or Cronbach's of the scale was 0.90 (Rapaport, Clary, Fayyad, & Endicott, 2005).

Sociodemographic Variables

Sociodemographic information was obtained on all voluntary participants through the Demographic Form (see Appendix B). The information consisted of (a) age, (b) gender, (c) racial group,(d) insurance status, (e) insurance type, (f) lapse in insurance coverage, (g) employment status, (h) type of employment, (i) level of education, (j) college attendance, (k) generational status, (l) income range, (m) health status, (n) date of last physician visit, and (o) a list of common health problems. The participants were also asked to share medical diagnosis which included questions assessing disease processes of: (a) High Blood Pressure, (b) Obesity, (c) Anxiety or Depression, (d) Cancer, (e) Diabetes, (f) Asthma, (g) Arthritis, (h) Heart Attack or Heart Disease, and (i) any other health problems.

Data Collection and Coding

The questionnaires were coded by location and collected by the P.I. Adults volunteering to participate were asked to report to a designated area. Verbal instructions were provided by the P.I. (see Appendix I). The information letter and the four-part questionnaire were distributed in a brown pull and seal catalog envelope with a blank sheet of paper to provide a cover shield for participants as responses were answered. Participants were asked to read the Information Letter (see Appendix A) with IRB information provided. Adults ages 19 and over residing in the extended Black- Belt counties willing to comply with the study requirements completed the four-part questionnaire. Implied consent was indicated by participation. Each participant was provided a copy of the Information Letter. Adults ages 19 and over residing in the extended Black Belt counties completed the four-part survey (see Appendix B). Scoring of each questionnaire was done according to guidelines provided the authors of the instruments.

Summary

SAS was used in data analysis. Reliability for the instruments was determined by reporting the internal consistencies and the Cronbach's alphas. A comparison was made with prior reliabilities reported for each instrument. The Pearson product moment correlation coefficient was used to determine the strength of the relationship among the selected variables of mistrust, positive and negative hope and quality of life satisfaction. The level of significance for testing was 0.01. Multiple regression analysis on the independent variables, mistrust and hope with quality of life satisfaction was accomplished to determine explanatory variance.

Chapter IV discusses the results of the study. The results include the description of the sample for sociodemographics and behavioral characteristics. The results also include internal consistency, reliability for each instrument and analysis of the research questions.

CHAPTER IV: RESULTS

Chapter IV presents the results of the data analysis and is divided into three sections. The first section represents a description of the sociodemographic variables for the total sample (N = 308) and selected demographic variables. The second section contains the internal consistency reliabilities for each instrument used in the study. The third section represents the research questions with data interpretation.

Sociodemographic Variables

All participants of this study were recruited from the Alabama SEDSC. Dr. C.P. Noble presently presides as President. The Alabama SEDSC is a district affiliated with the Alabama State Missionary Baptist Convention, Incorporated (Inc.). The National Baptist Convention (NBC) United States of America (U.S.A.) Inc. is the parent body of these conventions, encompassing more than 32,000 churches with a membership of more than 8 million parishioners. This conglomerate is the largest black denomination in the United States (World Council of Churches, 2006)

The convention site for the 97th session of the SEDSC convened at the Enterprise Convention Center in Enterprise, Alabama. On May 13–17, 2010, parishioners from the SEDSC traveled from various counties in Alabama's Extended Black Belt. The total population of attendees at the Missionary Baptist Church faith-based conference was approximately 750. The non-random convenience sample for the study was 308 adults, which provided a participation total of 41.06 percent participation rate. One hundred and thirty eight (138) churches in the Southeast district registered for this annual event.

The SEDSC is progressive and deliberate in attempts to evoke positive ecumenical and community changes. Churches are involved in Christian education efforts both abroad and locally supporting community ventures, developing and educating parishioners' holistically in Christian work and service from varied societal perspectives. Monthly 1st Saturday meetings are designated in the district for adult and youth development, which is central to the mission of the SEDSC. For example in 2009 at the 42nd annual Youth Rally, 1500 delegates attended this event which was held at one of the Universities in the area. Youth participate and compete in events such as Banner Construction, Drill Team/Step Team, Pantomime/Praise Dance, Choir Sing-off, Bible Bowl essays and oratorical competitions.

The Greater St. Mark Missionary Baptist Church in Tuskegee, Alabama, where Dr. C.P. Noble presides as pastor, is situated just on the outskirts of the town line, very close to the heart of downtown Tuskegee and was also a site for data collection. Tuskegee University is a few miles from Greater St. Mark Missionary Baptist Church. Historically, Greater St. Mark Missionary Baptist Church garners an immense and rich history in Tuskegee (Alabama) and throughout the state and nation, and thus is one of the lead churches in Macon County. Some of the central figures in the USPHS Tuskegee Syphilis Study of the Negro Male could have possibly attended this worship body. To maintain anonymity, no disclosures will be made in this study of anyone directly involved with the USPHS Study of Untreated Syphilis in the Negro Male.

Data Analysis

Preliminary Analysis

All data analyses were performed using SAS statistical software, version 9.2 (SAS, 2010). Descriptive statistics describe and summarize data including frequencies, percentages, means, medians, modes, ranges, and standard deviations. Inferential statistics included bivariate statistical tests, t-test procedures, Pearson correlations, and mutivariate methods included multiple regression analysis to answer the research questions. Cronbach's coefficient alpha was calculated to estimate the internal consistency reliabilities' of the H2HM, Endicott's General Activities subscale of Q-LES-Q, and the LaVeist Mistrust V2.2 scales. *P*-values less than or equal to .05 were considered significant.

Presentation of Results

Table 4 indicates frequencies and percentages for characteristics of variables. Of the 310 participants in this study, 67% (n = 208) were male, 97% (n = 298) were Black, 47% (n = 145) were 56–69 years old, and 22% (n = 67) were not currently insured.

Table 4

Demographic Characteristics of the Population Sample

Characteristics	n	Percentage
Sex		
Female	100	32.47
Male	208	67.53
Race		
Black	298	96.75
Other	10	3.25
Age		
19–25	8	2.61
26–35	14	4.56
36–55	85	27.69
56–69	145	47.23
70 or more	55	17.92
Are you Currently Insured?		
Yes	67	21.75
No	241	78.25

Table 5 shows the number, means, standard deviations, and minimum-maximum for the study. The results indicated that the mean for total hope, total health care problem (demographics), total health care (trust), and total satisfaction were 72.13, 9.92, 20.31, and 62.14 respectively.

Table 5

Number (N), Mean, Standard Deviation (SD), and Ranges of Variables

Label	**N**	**Mean**	**Std Dev**	**Minimum**	**Maximum**
Total / Health Care Problem	299	9.92	6.74	1.00	18.00
Total / Health Care	303	20.31	4.59	2.00	28.00
Total / Hope	307	72.13	12.57	15.00	88.00
Hope / Negative	304	28.37	6.43	2.00	36.00
Hope / Positive	307	44.03	7.42	11.00	52.00
Total / Satisfaction	300	62.14	10.22	5.00	80.00
MEAN / Health Care Problem	299	1.44	0.40	1.00	2.00
MEAN / Health Care	303	2.95	0.61	1.00	4.00
MEAN / Hope	307	3.38	0.43	2.00	4.00
MEAN / Hope/Negative	304	3.25	0.61	1.00	4.00
MEAN / Hope/ Positive	307	3.47	0.48	1.08	4.00
Mean / Total / Satisfaction	300	4.03	0.54	1.00	5.00

Table 6 provides sociodemographic characteristics of the sample by age and gender. The mean age is 3.7 for both male and female (both age groups are between 36 and 69 years of age). No one is represented under the ages of 25 (males vs. females). The sample was comprised of 32.47% (n = 100) females and 67.53% (n = 208) males. Percentages of males' attendees at the convention were higher in each age category: 2.61% (n = 19–25), 2.93% (n = 26–35), 16.94% (n = 36–55), 31.27% (n = 56–69) and 13.68% (n = 70 and more). The age categories with the higher percentage of females among female attendees were15.9% (n = 56–69).

Table 6

Sample by Gender and Age

SEX(SEX)		**AGE(AGE)**					
		19–25	26–35	36–55	56–69	70 or more	Total
Female							
	Frequency	0	5	33	49	13	100
	Percent	0.00	1.63	10.75	15.96	4.23	32.57
	Row Pct	0.00	5.00	33.00	49.00	13.00	
	Col Pct	0.00	35.71	38.82	33.79	23.64	
Male							
	Frequency	8	9	52	96	42	207
	Percent	2.61	2.93	16.94	31.27	13.68	67.43
	Row Pct	3.86	4.35	25.12	46.38	20.29	
	Col Pct	100.00	64.29	61.18	66.21	76.36	
Total							
		8	14	85	145	55	307
		2.61	4.56	27.69	47.23	17.92	100.00

Note. Frequency Missing = 2

Table 7 reports family annual income level. More than half (52.04%) of the participants reported annual incomes of greater than $35,000. An income of $ 90,000 or 4.08% (n = 12), was reported by members of the sample population.

Table 7

Sample by Family Annual Income Level

Income	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Less than $5,000	20	6.80	20	6.80
$5,000 – $9,999	21	7.14	41	13.95
$10,000 – $14,999	25	8.50	66	22.45
$15,000 – $34,999	75	25.51	141	47.96
$35,000 – $54,999	70	23.81	211	71.77
$55,000 – $65,999	34	11.56	245	83.33
$66,000 – $89,999	37	12.59	282	95.92
$90,000 or more	12	4.08	294	100.00

Table 8 reports the insurance status of the sample population. The majority of the population maintained current health insurance with 78.25% (n = 241) reporting that they were insured, while only 21.75% (n = 67) participants in the sample were uninsured. Only 15.8% (n = 46) participants reported that there was a time during the past two years when they were completely without any health plan or insurance coverage, 57.12% (n = 176) had private insurance, with 16.88% (n = 52) having Medicare.

Table 8

Sample by Insurance Status

TINS	Frequency	Percent	Cumulative Frequency	Cumulative Percent
NONE	21	6.82	21	6.82
PRIVATE HLTH INSUR	176	57.14	197	63.96
MEDICARE	52	16.88	249	80.84
MEDICAID	18	5.84	267	86.69
CHAMPUS/CHAMPVA	12	3.90	279	90.58
OTHER	29	9.42	308	100.00

Table 9 shows participants employment status. Thirty-five percent (n = 105) reported working outside the home full time, while 7.33% (n = 22) work part time, 34% (n = 102) were retired, 2.67% (n = 8) were attending school, 0.67% (n = 2) reported maintaining the home, 4.00% (n =12) were unemployed, 12.33% (n = 37) were disabled, and 4% (n = 12) reported non-specified as other.

Table 9

Sample by Employment Status

Employment Status	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Working Full-Time	105	35.00	105	35.00
Working Part-Time	22	7.33	127	42.33
Retired	102	34.00	229	76.33
Attending School	8	2.67	237	79.00
Maintaining the Home	2	0.67	239	79.67
Unemployed	12	4.00	251	83.67
Disabled	37	12.33	288	96.00
Other	12	4.00	300	100.00

Table 10 reports job description type by participants in the population sample. Participants reported being employed as Executive/Managerial, 48.28% (n = 98), the highest occupational type in this population followed by Technical/Sales/Administrative, 21.67% (n = 44), Helpers/Laborers, 16.75% (n = 34), Service Occupations 10.84% (n = 22), and Craft Persons/Mechanics/Installers, 2.46% (n = 5).

Table 10

Sample by Employment Category

Type of Job	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Helpers/Laborers	34	16.75	34	16.75
Craft Persons/Mechanics/Installers	5	2.46	39	19.21
Service Occupations	22	10.84	61	30.05
Technical/Sales/Administrative	44	21.67	105	51.72
Executive/Managerial	98	48.28	203	100.00

Table 11 reports the highest educational level of participants in the sample. In this population, those members of the sample who were awarded a Master’s Degree or higher reflected 24.75 % (n = 73). Members of the sample who completed high school were comprised of 21.36% (n = 63) while those who completed college included 21.02 % (n = 62).

Table 11

Sample by Educational Level

Educational Level	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Elementary School	13	4.41	13	4.41
High School	63	21.36	76	25.76
Trade /Vocational School	37	12.54	113	38.31
Attended College	46	15.59	159	53.90
Completed College	62	21.02	221	74.92
Master's Degree	73	24.75	294	99.66
Doctor Level	1	0.34	295	100.00

Table 12 reports generational college status of participants. Only 23.78 % (n = 68) of the sample population, conveyed being the first in the family to graduate from college. Of the sample, 76.22% (n = 218) reported having a generational status of college-educated parents.

Table 12

Sample by Generational College Status

First Graduate	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	68	23.78	68	23.78
No	218	76.22	286	100.00

Table 13 shows reported health status of the participants. Members of this sample who reported good health were 47.87 % (n = 146). In comparison, those in excellent health were 6.73% (n = 19).

Table 13

Sample by Health Status

Health Status	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Excellent	19	6.23	19	6.23
Very Good	71	23.28	90	29.51
Good	146	47.87	236	77.38
Fair	67	21.97	303	99.34
Poor	2	0.66	305	100.00

Table 14 reports the length of time since the participants' last physician visit. Seventy-three percent (n = 67) of participants reported to have visited their physician within the last two months. While 9.84% (n = 30) of the sample population reported a physician visit 1 year ago.

Table 14

Sample by Last Physician Visit

Last Visit to a Physician	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1 Week Ago	44	14.43	44	14.43
2 Weeks Ago	27	8.85	71	23.28
3 Weeks Ago	39	12.79	110	36.07
4 Weeks Ago	47	15.41	157	51.48
2 Months Ago	67	21.97	224	73.44
6 Months Ago	51	16.72	275	90.16
1 Year Ago	30	9.84	305	100.00

Table 15 reported sample by previously diagnosed health alterations. Of the sample previously diagnosed with health problems, hypertension n = 201(71.9 %) was the highest, followed by arthritis 60% (n = 138), diabetes 37.21% (n = 80), obesity 32.97% (n = 60) and anxiety/depression 17.42% (n = 31). Participants reported any other health problems of 40.11% (n = 75).

Table 15

Sample by Previously Diagnosed Health Problem

Health Problem	N	Percent
High Blood Pressure	201	71.79
Heart Attack or Heart Disease	28	15.38
Cancer	26	14.29
Diabetes	80	37.21
Anxiety or Depression	31	17.42
Obesity	60	32.97
Asthma	31	16.94
Arthritis	138	60.00
Any Other Health Problem	75	40.11

Inferential Statistics

Table 16 shows intercorrelations, and coefficient alpha reliabilities. Scale reliability was assessed by calculating coefficient alphas. Reliability estimates were shown in the diagonal on Table 16. The result revealed all reliabilities exceeded .70 with the exception of Part I of the four- part survey of the demographic scale of health care problems with a reliability of (0.57). The results indicated that total satisfaction is related to total hope, positive and negative. Also, health care problem is related to the total hope and its subscales.

Table 16

Intercorrelations and Coefficient Alpha Reliability of Selected Scales and Subscales

	Pearson Correlation Coefficients					
	tsat	**thp**	**thcare**	**hopen**	**hopep**	**thope**
tsat – total / satisfaction	**0.93**	0.11214	0.05986	**0.40833**	**0.48382**	**0.55892**
Prob > |r| under H0: Rho=0		0.0560	0.3038	**< .0001**	**< .0001**	**< .0001**
Number of Observations		291	297	**298**	**300**	**300**
thp – total / health care problem		**0.57**	0.04797	**0.14893**	**0.14810**	**0.18854**
Prob > |r| under H0: Rho=0			0.4125	**0.0104**	**0.0105**	**0.0011**
Number of Observations			294	**295**	**298**	**298**
thcare – total / health care			**0.89**	0.07806	-0.02713	0.02806
Prob > |r| under H0: Rho=0				0.1768	0.6387	0.6271
Number of Observations				301	302	302
hopen – hope / negative				**0.87**	0.47588	0.84230
Prob > |r| under H0: Rho=0					< .0001	<.0001
Number of Observations					304	304
hopep – hope / positive					**0.92**	0.88068
Prob > |r| under H0: Rho=0						<.0001
Number of Observations						307
thope – total / hope						**0.91**

Note: Reliability Alpha Coefficient on the Diagonal.

Table 17 shows intercorrelations of total satisfaction with select demographical findings. The results indicated that total satisfaction is related to health status, income, and education.

Table 17

Intercorrelations Total Satisfaction with Some Selected Variables

	Pearson Correlation Coefficients					
	tsat	AGE	HSTAT	INCOM	EDUC	LVISIT
tsat – total / satisfaction	1.00000	0.00330	**-0.40325**	**0.23168**	**0.17797**	0.03795
Prob > |r| under H0: Rho=0		0.9547	**<.0001**	**<.0001**	**0.0024**	0.5147
Number of Observations		299	**297**	**287**	**288**	297
AGE		1.00000	0.16111	0.06685	0.07569	-0.19798
Prob > |r| under H0: Rho=0			0.0049	0.2540	0.1956	0.0005
Number of Observations			304	293	294	304
HSTAT			1.00000	-0.24176	-0.22340	-0.25341
Prob > |r| under H0: Rho=0				<.0001	0.0001	<.0001
Number of Observations				292	293	305
INCOM				1.00000	0.50608	0.00548
Prob > |r| under H0: Rho=0					<.0001	0.9256
Number of Observations					287	292
EDUC					1.00000	0.08219
Prob > |r| under H0: Rho=0						0.1606
Number of Observations						293
LVISIT						1.00000

Table 18 is the result of the multiple regression models on selected variables on total satisfaction. This table indicates that both hope subscales (negative and positive) and health status are related to total satisfaction. However, health care problem, health care, education, and income were not related to total satisfaction. Thirty-two percent variability of total satisfaction are explained by all of these variables in the model.

Table 18

Multiple Regression for Selected Variables on Total Satisfaction

Selected variables [a]	Parameter Estimate	Standard Error	t Value	Pr > |t|	Standardized Estimate
Intercept	44.99560	4.81700	9.34	<.0001	0
total / health care problem	-0.02040	0.07243	-0.28	0.7784	-0.01466
total / health care	0.10506	0.10317	1.02	0.3095	0.05230
hope/ negative	0.31135	0.09096	3.42	0.0007	0.20192
hope/ positive	0.34119	0.08014	4.26	<.0001	0.24592
Health Status	-3.39609	0.60323	-5.63	<.0001	-0.30321
Education	-0.34899	0.35645	-0.98	0.3284	-0.05955
Income	0.61824	0.32236	1.92	0.0562	0.11638

[a] R-Square = 0.32

Table 19 is the result of the multiple regression models on selected variables on total satisfaction. This table indicates that total hope and health status are related to total satisfaction. However, health care problem, health care, education, and income were not related to total satisfaction. Thirty-two percent variability of total satisfaction are explained by all of these variables in the model.

Table 19

Multiple Regression for Selected Variables on Total Satisfaction

Selected variables [a]	Parameter Estimate	Standard Error	t Value	Pr > |t|	Standardized Estimate
Intercept	45.24657	4.65807	9.71	<.0001	0
Total / Health Care Problem	-0.02051	0.07230	-0.28	0.7769	-0.01474
Total / Health Care	0.10274	0.10240	1.00	0.3166	0.05115
Total/ Hope	0.32764	0.04749	6.90	<.0001	0.37994
Health Status	-3.40495	0.60066	-5.67	<.0001	-0.30400
Education	-0.35339	0.35518	-0.99	0.3207	-0.06030
Income	0.61307	0.32083	1.91	0.0571	0.11541

[a] R-Square= 0.32

Analysis of Research Questions

In this section, the results of the analysis of the data in relation to the research questions are presented.

Research Question One

This question asked, “What is the level of mistrust in the Healthcare System as measured by the LaVeist Medical Mistrust Index V2.2? Table 20 provides detailed analyses of the Cronbach’s coefficient alphas for questions addressed on the LaVeist MMI V2.2 scale.

Table 20

Cronbach's Coefficient Alpha with Deleted Variable

Deleted Variable	Raw Variables		Standardized Variables		Label
	Correlation with Total	Alpha	Correlation with Total	Alpha	
HCARE1	0.544515	0.890643	0.544302	0.891324	Caution on dealing health organizations
HCARE2	0.707255	0.870052	0.707426	0.872037	Patients sometimes deceived or mislead
HCARE3	0.721186	0.869185	0.722891	0.870151	Health organizations cover their mistakes
HCARE4	0.725805	0.867656	0.728528	0.869461	Health orgs do harmful experiments on patients
HCARE5	0.700859	0.870741	0.701047	0.872812	Health orgs do not keep information private
HCARE6	0.695617	0.871405	0.696236	0.873396	You wonder health orgs know what they do
HCARE7	0.704272	0.870449	0.704911	0.872343	Mistakes are common in health orgs

Pearson Correlation Coefficients indicated no statistical significance of mistrust in the health care system to either positive or negative hope or quality of life satisfaction, when analyzing mistrust of the health care system on the LaVeist MMI V2.2 scale. The reliability of the LaVeist MMI V2.2 scale in this study is .87; the previous alpha for the LaVeist Mistrust V2.2 scale was .76 in the Baltimore study. Data analysis revealed there was no difference or no effect of the LaVeist MMI V2.2 on the dependent variable of quality of life satisfaction, the LaVeist MMI V2.2 showed no relationship to the covariant dependent variable of total hope (i.e. positive and negative hope). Multiple regression models and intercorrelations were conducted to derive these findings.

Of the seven items on the LaVeist MMI V2.2 scales, in determining levels of mistrust of the healthcare system 52% (n = 156)of the sample agreed that caution was needed when dealing with health organizations, 55.22% (n = 164), agreed that patients sometimes were deceived or mislead. When asked if there was a belief that health care organizations cover up their mistakes, more than half of the population sample agreed 58.72% (n = 175). The belief by the sample population that health organizations do harmful experiments on patients, 48.63% (n = 142) agreed, with 31.85% (n = 83) strongly agreeing, with a combined tabulation of agree and strongly agree of 80.48 % (n=225). In assessing if health care organizations kept information private, 52.82% (n = 159) agreed that healthcare organizations do not keep information private. When asking if health care organizations know what they do, 46.64% (n = 139) agreed, with 17.79% (n = 53) strongly agreeing, that health care organizations do not know what they do. The last item on the LaVeist MMI V2.2 assessed if mistakes are common in health care organizations, 53.69% (n = 160) agreed, with 18.12% (n = 54) strongly agreeing.

Scores on the LaVeist MMI V2.2 scale found high mistrust in the sample population surveyed in Alabama's expanded Black Belt. For example, on the question of (i.e. "Healthcare organizations have sometimes done harmful experiments on patients without their knowledge) with 71.81% (n = 235) of the sample population agreeing, when tabulating strongly agree and agree for a combined total score. These data determined high mistrust in the Black Belt South for this faith based community with the higher scores for agree and strongly agree on the LaVeist Mistrust V2.2 scale.

Research Question Two

This question was "What is the level of Hope as measured by the Hendricks/Murdaugh/ Hendricks Hope Scale?" The data analysis results indicated that the independent variable total hope (i.e. positive and negative), had positive correlations to the dependent variable of total satisfaction. Also, health status is related to the total hope and its subscales. Independent variables of total hope and health status were statistically significant at (p < .0001).

Table 21

Intercorrelations, and Coefficient Alpha Reliability of selected Scales and Subscales

	Pearson Correlation Coefficients					
	tsat	thp	thcare	hopen	hopep	thope
hopen – hope/ negative				**0.87**	0.47588	0.84230
Prob > |r| under H0: Rho=0					<.0001	<.0001
Number of Observations					304	304
hopep – hope/ positive					**0.92**	0.88068
Prob > |r| under H0: Rho=0						<.0001
Number of Observations						307
thope – total/ hope						**0.91**
Prob > |r| under H0: Rho=0						
Number of Observations						

The alphas' for the H2HM Hope scale are: negative hope 0.87, positive hope 0.92 and total hope 0.91. Combined hope scales had an alpha of 0.91. On multiple regression models of coefficient of determination, the hope scales were statistically significant at (p < .0001). The independent variable total hope is significantly correlated with the dependent variable total satisfaction. These data determined that positive hope existed in the identified expanded Black Belt counties of the participants surveyed in this faith based community, with the higher scores for "disagree" and "disagree strongly" on the H2HMS for the question, "hopeless about some parts of my future." With 79.52 % (N = 233) of the sample population disagreeing, that they were hopeless when tabulating, “disagree strongly” and “disagree” for a combined total score. Positive Hope is also evident, as reported by reviewing the question, “I am positive about the future.” with 94.33 %(N=283) when combining total scores of “agree” and “strongly agree” on the H2HMS.

Research Question Three

This question asked, “What is the quality of life satisfaction as measured by the Endicott Short Form General Activities subscale of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)?” Data analysis revealed that quality of life satisfaction is positively correlated with hope negative $r = 0.40833$ ($p < .0001$), hope positive $r = 0.48382$, ($p < .0001$), and total hope $r = 0.55892$, ($< .0001$).

In reviewing multiple regression models (Table 9) on variables of trust levels, (i.e. Hypertension-any healthcare problems (MMI V2.2), demographic variables of income and education, none of the afore-referenced variables were related to total satisfaction, given 32% variability. However, both hope scales positive and negative were related to total satisfaction. The independent variable total hope was correlated with the dependent variable of total satisfaction and was significant at ($p < .0001$). Participants from the sample population reported a positive quality of life enjoyment and satisfaction as evidenced from the report of the overall rating of the question, “Rating of Life Satisfaction” of 90.14%(N=265) of combined scores of “good” and “very good” and as reported from the question encompassing a “Sense of Well Being” of 86.78%(N=256) with combined scores of “good” and “very good”.

Research Question Four

Research question four asked, “What is the relationship of mistrust in the Health Care system and Hope to the quality of life satisfaction among adults in Alabama’s Expanded Black

Belt?" Pearson correlation coefficients indicated that mistrust in the health care system was not statistically significant to the covariant of the hope scale and to the dependent variable of quality of life satisfaction. The MMI (assessed mistrust in health care organizations). Scores derived from the MMI were not positively correlated with quality of life satisfaction. Intercorrelations on total satisfaction indicated that total satisfaction is related to health status(i.e. "Would you say that it is excellent, very good, good, fair, or poor"?), income, and education. Total Hope is positively correlated with Quality of Life Satisfaction.

Table 22

Pearson Correlation Coefficients for Quality of Life Satisfaction

	Pearson Correlation Coefficients					
	tsat	AGE	HSTAT	INCOM	EDUC	LVISIT
tsat – total / satisfaction	1.00000	0.00330	**-0.40325**	**0.23168**	**0.17797**	0.03795
Prob > |r| under H0: Rho=0		0.9547	**<.0001**	**<.0001**	**0.0024**	0.5147
Number of Observations		299	**297**	**287**	**288**	297

Pearson correlation coefficients indicated that health status, income and education are statistically significant and related to the dependent variable total satisfaction. Health status is statistically significant at $p < .0001$, $r = -0.40325$. A positive correlation is associated with income at $p < .0001$, $r = 0.23168$ and generational education status at $p < 0.0024$, $r = 0.17797$. The Hope scales showed the following correlations, Hopen $r = 0.35726$ ($p < .0001$), hopep, $r = 0.31287$ ($p < .0001$), and thope $r = 0.36080$ ($p < .0001$). Pearson correlation coefficients indicated that thope, hopen, hopep, health status, income and education are statistically significant and related to the dependent variable of quality of life satisfaction.

CHAPTER V: DISCUSSION AND CONCLUSION

> Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. (p. 3)
>
> Commission on Social Determinants of Health

The quantitative design of this study explored the interrelationships of mistrust, hope and quality of life satisfaction of adults in Alabama's extended Black Belt in a faith-based community. The Black Belt counties, and the site for this study, are situated in the Deep South; most are very rural in composition. Data were collected utilizing a four-part survey inclusive of demographical analysis, the LaVeist Medical Mistrust Index; the MMI V2.2, the Hendricks/Murdaugh/ Hendricks Hope Scale; the H2HMS, and the short form of Endicott's Quality of Life Enjoyment Questionnaire; the Q-LES-Q. The study explored areas of mistrust, hopefulness and hopelessness and quality of life to Alabama's residents' in the expanded Black Belt. The population surveyed for this study were members from a convenience sample from a faith-based community; the SEDSC. The sample population included 310 individuals, ages 19 and above. Some older individuals chose to proudly write their ages onto the demographical section of the survey disavowing the constraint of a stipulated category of age. Participants in their late eighties and early nineties elected to participate in the study, evoking a unique and rich essence of meaning, seemingly for them as well as the Principal Investigator.

A legacy of unethical experimentation in health endeavors is not unique to the historical features of the Deep South, extending to vulnerable individuals and groups who are low on power, in an inequitable power structure and altered social relationships. The USPHS Tuskegee Study of Untreated Syphilis occurring over 82 years ago extends reverberations to the 310 participants of the population sample in this study.

Study Overview

This chapter will provide an overview of the significance of the study, reiterate pertinent findings and review the conceptual model which guided the study. Health care in the United States is unequal! Williams, McClellan, and Rivlin (2010) conveyed, “America’s health needs to be improved now, not five or ten years from now” (p. 1486). The main function of a health care system is to promote adequate and equitable access with consistent delivery of high quality care to all American citizens (Jensen, 2009; Manichikanti & Hirsch, 2013). WHO (2008) articulated,

> Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources. (p.22)

Social scientists and medical ethicists bear a critical responsibility to provide a lens of critical consciousness, in essence to empower those who are socially deprived of resources and goods to survive a world which provides inequality and unequal life chances. WHO (2008) declared, “Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death” (p. 3).

Nagel (2005) posited, “Justice … is concerned with the relations between the conditions of different classes of people, and the causes of inequality between them” (p. 1). Struggling with poor health is a common challenge for the minorities and the poor. The inability to access the health care system is problematic. Health care reform, although not providing universal coverage, has within its scope the potential to offer many Americans adequate health care coverage, thereby improving access and quality. However, the Governor of Alabama has elected not to participate with the requirements of *The Patient Protection and Affordable Care Act (PPACA)*, thereby providing freefall to the historical legacy of unequal treatment. The health care of those who need it most will continue to be compromised, and thus impact varied domains of the acquisition of social goods and a life quality which would promote the actualization of potential. How individuals conceptualize themselves is relative to a positive or negative health status (Pender, 1996).

The review of literature revealed problematic barriers associated with trust in the health care system, for some groups of people, particularly disadvantaged minority and ethnic groups, presenting with many structural issues living in modern day America. A historical legacy of mistrust ensues in the Black community. Having and maintaining a sense of trust is essential when accessing the health care system and is a useful indicator in how medical care is initiated, received and continued. Trust is multidimensional and includes perceptions of technical and interpersonal skills of health care providers (Halbert, Armstrong, Gandy et al., 2006; Hall, Camacho, Dugan et al., 2002; Hall, Dugan, Zheng & Mishra, 2001; Thom, Ribisi & Luke, 1999a).

The trust of a minority people with a history of 2nd class citizenship and numerous structural inequities inclusive of inequitable healthcare has been challenged by a sentinel event which occurred in the Black Belt South, challenging the agency of Black Americans in the health care market place. The USPHS Tuskegee Study of Untreated Syphilis in the Negro Male is an exemplar for medical mistrust, mistreatment, invoking malfeasance and injustice to a group of vulnerable and disenfranchised Negro males who were primarily illiterate and tenet farmers residing in Macon County. Mistrust is problematic for many constituents in the Black community. Pinn (2011) posited, “It is not surprising that such historical abuses would result in fear and distrust of the medical establishment and of the concept of being in a research study—the fear of being treated as a “guinea pig” (p. 3).

Pinn (2011) postulated on the gravity of the governmental study of untreated syphilis in the twentieth century. Pinn (2011) confirmed,

> The USPHS Tuskegee Study of Untreated Syphilis in the Negro Male from 1932–1972 is an example in the twentieth century of egregious insult imposed upon African American men and women who arose from a history of chattel slavery. In an era of chattel slavery, the slave owner amassed all power of agency and control, the physician in essence could exploit and physically dehumanize with no regard for the sanctity of life and the physical pain associated with bodily harm. In essence, the power to sterilize and experiment was a common practice and slaves could be bought for the purpose for such use. The quality of life European American was esteemed in a higher regard than a Negro. In essence, experimentation deemed to be painful, too risky and objectionable for a European American was appropriate for a slave. (Pinn, 2011)

Elders (2011) conveyed the significance of the reverberations and impact of the legacy of the USPHS Tuskegee Study of Untreated Syphilis in Negro Male, occurring in 1932 which transcends decades. The social determinants of health encompass social location and space and a racial hierarchy and hegemony which usurps power and agency of people who manifest a lower power status than dominant members in American society. Elders (2011) implied, “There can never be a greater scar or a more open wound for US medicine or the USPHS than the legacy of the USPHS Syphilis study at Tuskegee. This study has been considered arguably the most infamous biomedical research study in US history” (p. ix). In a personal communication with Dr. Jocelyn Elders former US Surgeon General, a question was posed by this writer relative to the position sustained by Black males in American society and the lack of accomplished agency in productive realms in major facets of social life resultant in a paucity of social goods impacted by disparities in varied conjectures. The major cause of disparities of Black males from Dr. Elder perspectives, is related to, “education and SES and the long history I would say, of stress and abuse they have endured; abuse of women they could not protect; not being able to get a job, without determination, not just related to drive.” “Black men lack power and have no way of doing anything about it, power of the vote, money, not in control of power.” Dr. Elders clarified the elements of agency encompassing the five C’s of leadership which are inclusive of: “(a) clarity of vision, (b) competence, (c) consistency, (d) commitment, (e) control –“got to have control”. Dr. Elders further commented, “You cannot be at peace with yourself, if you are at war with yourself” (Personal communication, Jocelyn Elders, 2013).

Trust and hope have been identified as major characteristics influencing how individuals utilized constructive agency interaction and are so influenced in the health care market place. Hope is a powerful force of life which produces liveliness and vitality and bears an integral role in health behaviors (Dubree & Vogepohl, 1980; Northrop, 1996; Nelson, Roberts, & Snyder, 1996). “To be able to enhance hope, one must first know what hope actually is and from where it comes by identifying its true determinants” (Obayuwana &

Carter, 1982, p. 229). Hopeful individuals view health promotion behaviors as a positive life investment (Beyea, 1991). Groopman (2004) distinguished hope from optimism,

> Hope is one of our central emotions, but we are often at a loss when asked to define it. Many confuse hope with optimism, a prevailing attitude that "things turn out for the best". But hope differs from optimism, is rooted in unalloyed reality. Although there is no uniform definition of hope…. Hope is the elevating feeling we experience when we see—in the mind's eye—a path to a better future. Hope acknowledges the significant obstacles and deep pitfalls along that path. True hope has no room for delusion…. It changes us profoundly in spirit and in body. (p. xiv)

Quality of life satisfaction incorporates in a complex way, an "individuals' physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationships to salient features of the environment" (The WHOQOL Group, p. 1405). The significance of Trust in the health care system, perceived Hope and Quality of Life and their interrelationships are important concepts in the study of adults living in Alabama's extended Black Belt.

A lacuna in the literature denotes a need for this study to uncover a possible influence of trust, hope and quality of life satisfaction and their interrelationships on the agency of how individuals seek, actualize and utilize the healthcare market place making positive or negative health care choices. Identifying how adults living in the extended Black Belt Counties of Alabama perceive the health care system and the interrelationship of the concepts of trust, perceived hope and quality of life satisfaction will advance the body of knowledge. The literature gap is this specific area will be further explored; building new gestalts for model development in an effort to permeate lacunas for understanding disparities interrelated to healthcare disparity research.

Good healthcare promotes good education and healthy lifestyles. The potential will exist for future intervention models to promote more positive trusting relationships in the health care system. Identifying the conceptualizations of hopefulness or hopelessness, and the significance to quality of life satisfaction can influence how future models regarding sensitive health care should be conducted. Health literacy is essential to agency.

Corbie Smith (1999) articulated,

> Although the Tuskegee Syphilis Study involved African-American men, analogies can be extended across cultural lines. As Physicians who will be caring for an increasingly diverse nation, it is important that we understand the lasting implications of this study for our patients. The study has come to represent not only the exploitation of blacks in medical history, but the potential for the exploitation of any population that may be vulnerable because of race, ethnicity, gender, disability age of social class. (p. 5)

“Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” (WHO Constitution, 1948, p. 2).

Can there be trust and hope in a healthcare system for members of a subpopulation in a land as the literature uncovered, so entrenched with the historical legacy of Jim Crowism, and the continuation of de facto discrimination and injustice in the Black Belt of Alabama? Health care disparities and the many variables associated with inequities transcends nationally to a social group not accepted in mainstream American society-evidenced by less endowment of social goods, perceived from a biolognistic conceptualization of race, from a perceived subhuman existence, shaped by a stigma of inferiority; steeped in a history of chattel slavery.

Healing allows one to regain power, from varied vestiges; hope provides the sinew to operationalize the integration of past detrimental acts, and the wounds so inflicted. With healing, no one has the-power to have continued control over the loss of agency associated with physical and mental oppression, in spite of the reality of a physical existence of imperfections in a world with a continued legacy of racism in healthcare and the broader context of American society. A question was posed by this writer to Attorney Fred Gray, Civil Rights Attorney for the Negro men in the USPHS Untreated Syphilis Study in the Negro Male on April 2012 at the Civil Rights Museum in Tuskegee Alabama relevant to the continued perceived lack of trust of Black Americans of the health care system. Attorney Gray stated, "I'm not sure if I am qualified to answer that…but I know that the men would not want that. I attended hearings in Washington to make sure nothing like that would ever happen again" (Personal Communication, Fred D. Gray, 2012).

In the White House East Room on May 16, 1997, 5 living survivors from the pseudoexperimental study, were in attendance in Washington, D.C. for an official apology of the wrongful act committed by the US government from President Bill Clinton; Mr. Herman Shaw, Mr. Charlie Pollard, Mr. Carter Howard, Mr. Fred Simmons, and Mr. Frederick Moss. Three survivors had family members serve as proxies for attendance; Mr. Sam Doner, Mr. Ernest Hendon and Mr. George Key. A profound and declarative tone from President Bill Clinton relative to the USPHS role in the study was thusly stated,

> Medical people are supposed to help when we need care, but even once a cure was discovered, they were denied help, and they were lied to by their government. Our government is supposed to protect the rights of its citizens; their rights were trampled upon. Forty years, hundreds of men betrayed, along with their wives and children, along

> with the community in Macon County, Alabama, the City of Tuskegee, the fine university there, and the larger African American community.
>
> The United States government did something that was wrong -- deeply, profoundly, morally wrong. It was an outrage to our commitment to integrity and equality for all our citizens. (Transcript Presidential Apology, The White House, Office of the Press Secretary, May 16, 1997)

Statement of the Problem

In an open health system gambit, Louis W. Sullivan, M.D. Secretary, U.S. Department of Health and Human Services, 1989–1993 made the following statement, "The founding fathers of this county cited life, liberty, and the pursuit of happiness as inalienable rights for each citizen. Yet the quality of life—a healthy life—is, in the 1900s, still not assured for Black Americans" (Byrd & Clayton, 2002, p. 519). Bullard and Wright (2012) posited,

> The United States was built on a city of raced- based inequality in every aspect of the existing social structure, certain groups have been denied equal access or opportunity to achieve the inalienable rights to life, liberty and the pursuit of happiness (p,xvii),

Trust compromised impacts health care and health disparities to a disadvantaged social group in the expanded Black Belt of Alabama, secondary to a sentinel event, the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male.

Research Questions

1. What is the level of Trust in the Healthcare System?
2. What is the level of perceived Hope to Quality of Life Satisfaction?

3. What is the quality of life satisfaction as measured by the Endicott Short Form General Activities subscale of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q- LES-Q)?

4. What is the relationship of Trust in the Health Care system and perceived Hope to the quality of life satisfaction among adults in Alabama's Expanded Black Belt?

Use of Incentives

All participants were offered incentives for participating in the study. Freimuth (2001) et al. posited, "Incentives are one strategy used to enhance recruitment into research" (p. 807). Incentives to the faith-based sample population were inclusive of: (a) a Walmart $5.00 gift card, (b) a bottle of water, and (c) a certificate of completion. The incentives provided the conveyance of an act of gratitude from the Primary Investigator to the participants in the study. Each incentive seemed to be relished by the sample participants. The bottles of water seemed to be a source of delight, and served as a source of hydration not only for participants in the study but for varied speakers during the five day conference. The significance of water to a Christian faith-based community is analogous to life and living. McCabe (1999) articulated,

> … to come to God for the satisfaction of one's thirst is to experience life (Isaiah 55:1–3). Therefore, water may be used as a metaphor for spiritual life. Water as a symbol for renewal is also connected with God fulfilling his promises of a physical restoration (Ezekiel 47:9; Zechariah 14:8). In addition, when it is used as a metaphor for cleansing and renewal, God is the source of this cleansing water (Isaiah 4:4). (p. 88–89)

The $5.00 gift cards were highly valued by participants in the study. No matter the assumed socioeconomic status, the gift cards seemed to convey the essence of the spirit of gratuitousness from the P.I. for participation in the study. The PI experienced a spirit of anticipation and generativity from the participants, which was very humbling, a giving of “self” exuded from the sample population; this spirit was one of reciprocity. A most gratifying experience was to see elderly participants so willingly “offering self”, seemingly to convey the experience of being especial.

Study Findings

This study was conducted in a faith-based community in the Southeast District Conference in the Deep South. Sample participants were 19 years and older residing in the expanded Black Belt counties in Alabama. Findings will allow new paradigms relative to trust, hope and quality of life pertinent to an area in the Deep South still burdened by a legacy of a wrongful act by the USPHS to a powerless and marginalized group of Negro men, commencing in 1932 who were not treated for a treatable venerable disease; Syphilis. The lacuna which existed in the literature prior to this study allows for new models of development for addressing health and healthcare disparities.

Demographical Analysis

The convenience sample included a higher percentage of Black males, 67.53% (n = 208) in comparison to a female compliment of 32.47% (n = 100) with a racial composition of 96.75% (n = 298), Black Americans and other 3.25% (n = 10).

The health status of sample participants n = 236 (77.38%) reported excellent to good health. The sample size of “other” when asked for the race of the participants n = 10 (3.25%) was not large enough to support statistical differences in racial groups when reviewing the analysis of the difference of diagnosed health problems. Participants responded to the last physician visit, n = 275(90.17%) as being within a 6 month time period, with n = 30 (9.84%) reporting having seen a physician in the past year. There was not a question in the demographical section to assess if participants failed to keep a follow-up or kept a return appointment.

The sample as a whole was a highly educated group with n = 62 (21.02%) having completed college and n = 73 (24.75%) having attained a Master's degree of higher with one participant from the sample writing in having obtained a doctorate 0.34% (n = 1). Only 23.78% (n = 68) reported being the first in the family to graduate from college. As a group, sample participants reported coming from a higher socioeconomic background, with 52.04 % (n = 153) having incomes between $35,000–90,000.

Hypertension is the leading health problem with 71.79% (n = 201) in the sample population, followed by arthritis at 60% (n = 138).

Previously diagnosed chronic health problems from the sample population included: (a) hypertension, 71.9 %; (b) arthritis, 60%; (c) diabetes, 37.21 %; (d) obesity, 32.97%; and (e) anxiety/depression, 17.42%. Other health problems amassed 40.11%.

According to the Alabama Department of Public Health Department Annual Report (2011), "… cardiovascular disease (CVD) is the leading cause of death in Alabama," … "with heart disease and stroke", killing "more Alabamians than all forms of cancer combined" (p. 26). In 2012, diseases of the heart ranked number 1 with 12,935 Alabamians acquiring this disease at a rate of 251.8%, and diabetes ranked number 7 of which 7,1314 persons being diagnosed with a rate of 27.5%. The following statistics were prevalent disease diagnosis in 2012: (a) cerebrovascular diseases; 4 2,601, 54.4 percent, (b) essential hypertension; 12 556, 11.6 percent, and (c) suicide; 11 676, 14.1 percent. "Heart disease, the most common form of CVD, is the leading cause of death in Alabama, and ranks fifth in the nation in deaths due to stroke" (p. 26).

According to a compilation of data from the Alabama Department of Public, the United Health Foundations (2011) indicated,

> In Alabama, obesity is more prevalent among non-Hispanic blacks at 42.4 percent than non-Hispanic whites at 29.0 percent. The prevalence of diabetes also varies by race and ethnicity in the state; 15.3 percent of non-Hispanic blacks have diabetes compared to 10.9 percent of non-Hispanic whites. (Para 2)

It is essential and necessary to note, the CDC (2010) indicated,

> Alabama adults ranked second in the nation in overweight/ obesity, and sixth in youth overweight/obesity. This correlates to 65 percent of Alabama adults and 36.1 percent of Alabama youth. Approximately 31 percent of Alabama adults are obese. According to the 2010 Behavioral Risk Factor Surveillance System data, more than 473,000 people in Alabama are aware they have diabetes, with a 13.2 percent diabetes prevalence rate. This is compared to 25.8 million people nationally, with an 8.3 percent diabetes prevalence rate.

Demographical findings relative to health status from the sample participants in comparison to disease prevalence rates from the Alabama Department of Public Health, found similarities to hypertension and diabetes as being significant health alterations.

Trust

In assessing mistrust in the sample population, the findings indicated that even though the participants were highly educated, high mistrust existed in this subpopulation in the rural south, in an area that has been challenged by a historical sentinel event, of intentional untreated syphilis in the Negro male by the USPHS occurring over 82 years ago. Scores on the LaVeist MMI revealed high mistrust in the sample population surveyed in Alabama's expanded Black

Belt. For example, on the question of (i.e. “Health care organizations do harmful experiments on patients.”) with 71.81% (N=235) of the sample population agreeing, when tabulating “strongly agree” and “agree” for a combined total score. These data determined high mistrust in the Black Belt south for this faith-based community with the higher scores for “agree” and “strongly agree” on the LaVeist MMI.

Quality of Life Satisfaction

Quality of life domains from Endicott’s Q-LES-Q correlated with demographical findings for physical health which ranged from good to very good 90.14% (N = 265), with 21.48% (N = 64) of sample participants reporting fair health, 3.02% (N = 9) poor health, and 1.01% (N = 3) very poor health. The domain of mood on Endicott’s Q-LES-Q correlated with the positive hope on the H2MHS of the sample participants 81.17 % (N = 237) overall with participants being at peace with themselves ranging from good to very good 93.06% (N = 289). The demographic question of having being told of a diagnosis of anxiety or depression with 82.58% (N = 147) having not been told, and 42% (n = 319) having been told of a diagnosis of an anxiety or a depressive state.

Hope

When reviewing the analysis of question 9 on the H2MHS, “feeling so overwhelmed, nothing I do will help”, the significance of positive hope is viewed as being central to the demeanor of this faith based group (see Table 23). Data analysis revealed that participants in this sample conceptualized hope as being very positive. Only 13.26% (n = 39) of members in this faith-based community felt so overwhelmed that nothing would help.

Table 23

Survey Question HOPE 9-H2MHS

SO OVERWHELMED,NOTHING I DO WILL HELP				
HOPE9	Frequency	Percent	Cumulative Frequency	Cumulative Percent
DISAGREE STRONGLY	144	48.98	144	48.98
DISAGREE	111	37.76	255	86.73
AGREE	23	7.82	278	94.56
AGREE STRONGLY	16	5.44	294	100.00

Recommendations for Future Research

The faith based community convenience sample was a diverse population, a majority were black males making up the majority 67.53% (n = 208) with the greater percentage being ages 36 through 70 and over 122.84% (n = 285). It is important to assess trust/mistrust hope and the influence on quality of life across the life span in males ages 19 and above. According to Byrd et al. (2011),

> African American males, across all age groups, continue to report a lack of trust as a primary reason for their unwillingness to participate in biomedical research. There is an ongoing need to continue to seek advice, improve communication, and design research studies that garner trust and improve participation among African American males as a targeted underrepresented population. Such communication and dialogues should occur at all age levels of research development to assess current attitudes and behaviors of African American males around participation. (p. 480)

Health care reform has within it scope the ability to transform life across the generations, a pervasive attack on heath care disparities.

Future research in this effort should be holistic in approach to encompass new models of health care delivery. The disparity in health care impacts criminal justice, education and intersects with health status and socioeconomic status. It is necessary to make changes in the paradigmatic thinking of young Black males, beginning in lower elementary levels relative to stereotype threat vulnerability to inform sound and knowledgeable thinking. Steele (1997) found in his research that often Black students seek to identify and to be socially accepted by those who look like them, which can be aligned to intellectual and academic demise, conceptualized as stereotype threat. Steele (1997) conveyed,

> The theory assumes that sustained school success requires identification with school and its subdomains; that societal pressures on these groups (e.g., economic disadvantage, gender roles) can frustrate this identification; and that in school domains where these groups are negatively stereotyped, those who have become domain identified face the further barrier of stereotype threat, the threat that others' judgments or their own actions will negatively stereotype them in the domain. (p.613)

Models of health care should change thinking about the lack of none acceptance of behavior that should be embraced. Beginning with the myths of governmental abuse of the pseudoexperiment in Macon County, AL constructed by the USPHS should command urgent rhetoric with a correct presentation of knowledge relative to the study.

Anecdotally, the writer found that highly educated Black males across the age spectrum maintain the belief that the “government” injected the men with syphilis. These men stated that they would never agree to participate in biomedical studies, no matter the incentive. Although the “government” sought not to provide treatment to mostly tenant farmers and share croppers, it is useful dialogue to assess the thoughts and knowledge of younger males as well as females.

Participation in medical trials by Black males and females is useful in the development of models for sound health care. Assessing Trust levels in the Black Belt counties, and knowledge of younger individuals of the Untreated Syphilis Study in the Negro Male implemented by the USPHS and correcting inaccuracies are paramount.

Future pedagogical models of instruction should encompass and assess across the life span knowledge of the study and incorporating components of health literacy. Although, the instruments in this study failed to assess the accuracy of knowledge of the syphilis study by the USPHS (i.e. injecting the men with syphilis) with the current knowledge of the Guatemala study, the writer's thoughts are that the perpetual myth will be compounded that the USPHS injected the Negro men with syphilis, thus adding to conspiracy theories, which will certainly impact trust.

Educational models will need to be implemented to provide clarity regarding the two studies and conveying the restraints in place today, hopefully to make such an occurrence virtually impossible. Reinforcement should be made at very young ages of the significance of obtaining a sound education, thereby skirting the inequitable criminal justice system. Community intervention models will need to be implemented to target youth from disadvantaged backgrounds to provide guidance through developmental stages, when young men are most vulnerable to the pressure of peers. The education in most Black Belt schools is reflective of dual educational systems, segregation academies exist, and inadequate resources still exist in some Black Belt schools. However, the Macon County School System just recently made annual yearly progress (AYP). It is hopeful that this trend will continue.

Future research will include assessing across life span trust issues, issues associated with hopelessness and anomic thinking and quality of life. It is essential to destroy perpetual stereotypical myths associated with conspiracy theories in the Black Belt south connected to the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male. An ultimate outcome is to develop hope and change negative paradigmatic thinking, evoking a higher standard of living and quality of life. In the faith-based community of the Southeast District in the expanded Black Belt, hope was positive. Two of the questions on the H2MHS assessed the significance and meaning of luck in one's life associated with the processes associated with life and living. The questions as stated: "I do not have good luck in my life" and "I will not have good luck in life". The writer was approached and challenged more than once from participants in the study, with significance central to the Christian faith and journey. Select participants stated, "We are Christians, we don't believe in luck." An analysis of this question from instrumentation of the H2MHS when used in a faith-based setting perhaps changes to the phrasing of those specific questions or a revised H2MHS for use in a faith-based community.

Future research will include groups that could not be relegated to a faith-based community as a comparison to the participants in the SEDSC. Healthcare educational pamphlets should be developed and offered to future participants after completing the survey. Modules should be age-specific for school-aged children. It is important with the benefits which health care reform offers for Black Americans to fully embrace the preventive services to allay chronic medical problems, thus, potentially closing the disparity in health care that has existed since slavery.

In the SEDSC, a very useful model would be continued education in areas where analysis and findings of data analysis revealed health problems (i.e. hypertension and diabetes). Monthly topics at First Saturday meetings, pamphlets constructed to address health status and monthly health related topics. Health literacy is necessary and essential to confront health and health care disparities. A module will be developed with specifics regarding health promotion, bringing clarity to health terminology.

In summary, the following areas from the study will be explored and developed: (a) development of age specific educational models beginning in early elementary school targeting health literacy and education on the major facts of the USPHS Syphilis study; (b) First Saturday meetings to include monthly health topics with the development of educational pamphlets on the findings associated with health status of sample participants in the Southeast District, health literacy will be incorporated with the health topics; (c) future studies looking specifically at trust, hope, quality of life and healthcare under utilization in comparative groups (i.e. secular and Christian), assessing knowledge of the USPHS Syphilis study which occurred in Tuskegee, AL on national levels; (d) development of H.O.P.E. (Having Optimistic and Positive Efficacy) groups in the SEDSC specifically for students who are at risk for failure in academics associated with social variables and developmental issues; (e) construction and development of faith-based instruments for use in faith-based communities to assess trust, hope and quality of life; (f) publication of findings in lay and professional journals; (g) qualitative group exploration of variables in this study leading to grounded theoretical frameworks and new quantitative tools; and (h) reporting findings from this study to members of the SEDSC and on a national level.

Model Revisited

A conceptual model was framed for exploration from conceptual ideologies as result of an extensive and exhaustive review of literature in Chapter Two. An exploration of the literature did not uncover the interrelationship of the constructs of trust, hope and quality of life satisfaction in the Black Belt counties of Alabama. While studies have been conducted in the

Black Belt of Alabama, the focus was not on Hope, the unique variable in this study. The model was constructed to explore the essence of the meaning from a quantitative analysis of mistrust, hope and quality of life in a region that had been challenged by a sentinel event which occurred in the twentieth century, over 80 years ago, in the Black Belt of Alabama, Macon County, Alabama. A basic model was conducted (see Figure 1) to define the focus of the study. The result of data analysis on a four-part instrument confirmed the relationship of the variables from the H2MHS, the Mistrust V2.2 and the Q-LES-Q.

A revision of the model after the data were reviewed implored the significance of the derived model, post analysis. The newly derived model (see Figure 10) found positive correlations to the dependent variable of Quality of Life Satisfaction of H2HMS, education attainment, health status, and income. In a review of healthcare and social science literature, a connection to the variables and their significance to quality of life satisfaction were uncovered. Education, health status and income interrelate with health disparities. LaVeist, Bowie, and, Cooley-Quille (2000) posited,

> … it is well-documented that black persons and other racial and ethnic minorities have lower SES compared with white persons. These facts have led to speculation that racial and ethnic differences, in health status can be explained by underlying differences in SES (p. 8).

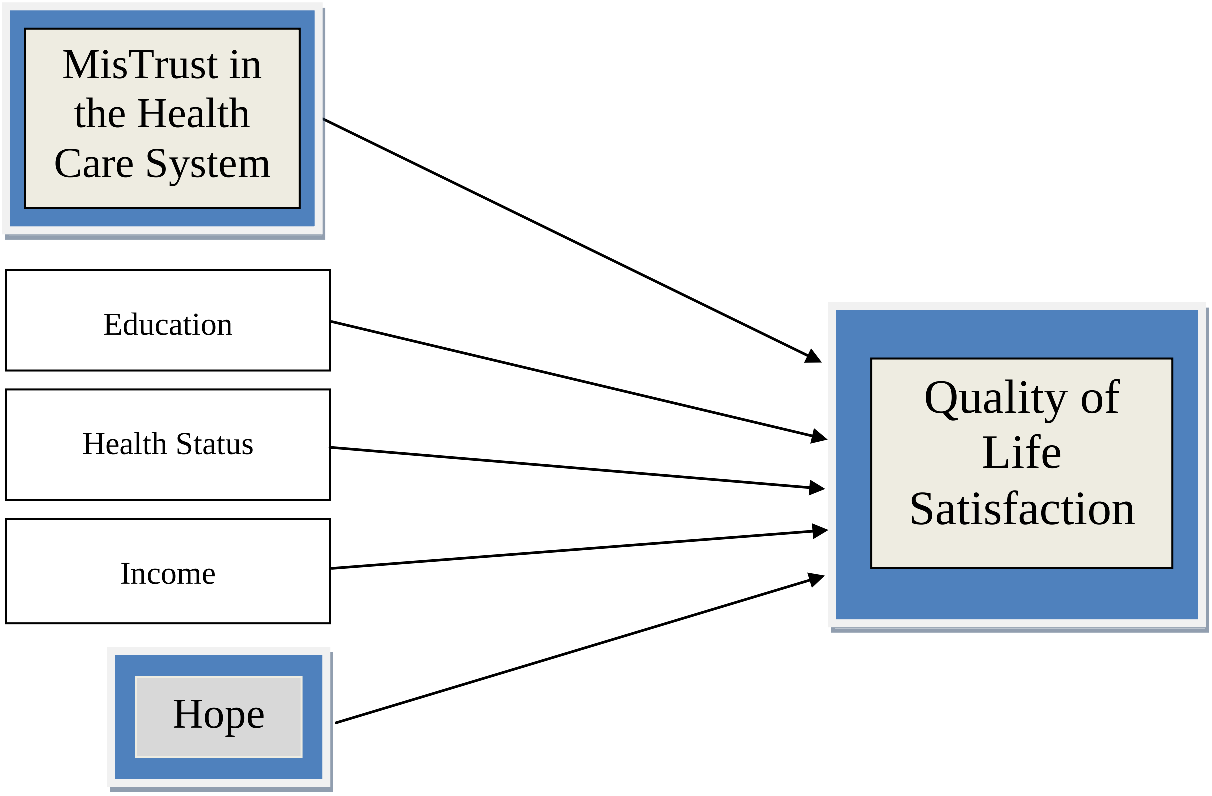


Figure 10. The Quality of Life, Hope and Mistrust Interrelationship Determinants Model

A lower SES aligns to the social gradient theory. Most certainly, social determinants interrelate and health status is impacted. Structural factors cannot become an isolative factor, but must be considered. The CDC MMWR (2011) stated,

> The socioeconomic circumstances of persons and the places where they live and work strongly influenced their health. In the United States, as elsewhere, the risk to healthcare and poor quality of care increases with decreasing socioeconomic circumstances. This association is continuous and graded across a population and cumulative over the life course. Educational attainment and family or household income are two indicators used commonly to assess the influence of socioeconomic circumstance on health. Education is a strong determinant of future employment and

> income. In the majority of persons, educational attainment reflects material and other resources of family of origin and the knowledge and skills attained by young adulthood. Income can influence health by its direct effect on living standards (e.g., access to better quality food and housing, leisure time activities, and health-care services). (p.13)

LaVeist, Bowie, and, Cooley-Quille (2000) posited of the distinct differences of cultural attributes and impact on health status and the perception of disease and illness and decisional choices regarding health care processes, with the ultimate impact on quality of life and health outcomes. The complexity of cultural unique properties on the agency of ethnic groups can reflect a specific world view. LaVeist, Bowie, and, Cooley-Quille (2000) stated,

> Cultural differences among racial and ethnic groups also contribute to health status differentials. Cultural beliefs, attitudes, and values can affect how patients perceive illness and disease, make decisions about medical treatments, and cope with health outcomes, including quality of life and disability. Ethnic and minority populations show patterns of health status, health care use, and mortality that are different from the white population; each of the groups brings its own unique set of cultural patterns. (p. 9)

LaVeist, Bowie and Cooley-Quille (2000) conveyed that distrust is not necessarily inherent to Black Americans cultural experience but stems from the agency of occurrences and exchanges of living in American society with the protrusion of dominance and oppression. LaVeist, Bowie and Cooley-Quille (2000) stated, “However, an attitude of distrust is not an aspect of black culture; rather distrust is more likely a reaction to exposures to discrimination and differential treatment” (p. 10).

Conclusion

Katz (2011) provided a detailed historical analysis of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male analyzing conducted scientific studies. An analysis by Katz determined that overall, “there is no association today between awareness of the USPHS Syphilis Study at Tuskegee and willingness to participate in biomedical studies, for either blacks or whites”, and “that blacks are equally as willing to participate in biomedical research” (p.xxxvi). Other scholars disagreement with Katz’s analysis.

Overall, the analyses of Katz’s scientific review of literature and research studies draw conclusions that, “African Americans are willing as any other racial group to participate fully in biomedical research” (p. xxxvii). Katz (2011) gives further credence to the Black American experience in the United States: “This finding seems to echo how African Americans have participated in the wider arena of life in the United States throughout the country’s history” (p. xxxvii). Acknowledging strength and resilience of the black community, Katz (2011) posited, “As a community, African Americans continuously demonstrate a willingness to participate and serve, but never without an intelligent wariness borne of the daily realities of being an African American in the United States” (p. xxxvii). Adding to the rhetoric, and understanding the essence of hope, trust, faith and spirituality as a whole for Black Americans, Katz (2011) affirmed,

> The history of the African American community in the U.S. is largely one of great patience with the persistent and institutionalized racism imposed by the white majority. Perhaps this patience is based in a sustained (and likely religious-based) belief by African Americans that eventually, in time, the whites will ‘get over—and beyond—it.’ (p. xxxvii)

However, Byrd et al. (2011) contended that as a group African American males were willing to participate in research studies; however, findings were consistent with lack of trust issues across all age groups, as the "primary reason for their unwillingness to participate in biomedical research" (p.480).

In a personal communication with Dr. C. P. Noble, a perspective is derived from a Black Pastor serving a Black congregant in Tuskegee, Alabama for over 30 years. Dr. Noble captured the essence of the depth of equality and fairness for a people who lack social acceptance in the broader realm of the Deep South. Dr. Noble conveyed, "Human beings deserve an opportunity to survive and succeed and thrive in their work. God decides to make us who we are, in spite of the melanin in one's skin, equality in the world should exist" (Personal communication, C. P. Noble, 2012).

Dr. Warren, director of the Bioethics Center at Tuskegee University, has the opportunity to explore extensively many variables of the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male with distinguished scholars who maintain a commitment to exploring gestalts relative to the existence of mistrust, underutilization of the health care system, healing of family members whose loved one who had no voice in a treatable disease and interrelated causes of disparities. Warren (2011) conveyed,

> …Surely within its cultural context and content, the legacy of the USPHS Syphilis study at Tuskegee is at the root of history—present and future—of African Americans and all people of goodwill. If appropriately addressed the souls of black folks can be cared for nurtured and healed. Until then, the soul of America will not be at peace. (p. 148)

Hope provides the sinew to life, when the pitfalls, the valleys which come to alter the smooth course of life, hope promotes the will to survive in spite of circumstances and conditions. The agency assumed as a result of alterations which come to take away the peaks of one's productivity if so granted, hope is essentially, the essence of endurance. The Negro men in 1932 had experienced devastation in respect to living life in the 19th and 20th centuries, through varied circumstances and alterations in an oppressive context of de jure discrimination evidenced in share cropping and tenancy farming, 2nd class citizenship and an assumed generational history of chattel slavery. Seeking perceived health care amounted to an anomaly, something that had not been heretofore experienced. The pseudoexperiment promoted devastation and loss, crippling actualized potential, not only to the men who did not willingly participant in the USPHS Tuskegee Study of Untreated Syphilis in the Negro Male, but also to family members in multigenerational contexts. Trust continues to be compromised in the expanded Black Belt counties in Alabama as findings revealed by the MMI. Though participants in the study, *Trust in the Healthcare System, the Perceived Hope to the Quality of Life Satisfaction in Alabama's Expanded Black Belt* were more highly educated, were not poverty stricken, had good to excellent health, were hopeful and maintained a high quality of life; however, the participants in the study continued a legacy of mistrust in the health care system. The powerful legacy of mistrust continues in the expanded Black Belt of Alabama, perhaps limiting the agency for participation in future medical trials when the opportunities are available.

REFERENCES

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review*, *96*, 358–372.

Agency for Healthcare Research and Quality (US). (2011, April 28). 2010 national healthcare disparities report. AHRQ publication no. 10-0004. Rockville (MD): AHRQ. Also available from: http://www.ahrq.gov/qual/qrdr09.htm

Agency for Healthcare Research and Quality (US). (2012, January). 2011 national healthcare disparities report. Rockville, MD. http://www.ahrq.gov/research/findings/nhqrdr/nhdr11/index.html

Agency for Healthcare Research and Quality. (2011, March 10). National healthcare disparities report, 2010. Rockville (MD): AHRQ. [cited 2011 Mar 10]. AHRQ publication no. 11-0005. Also available from: URL: http://www.ahrq.gov/qual/qrdr10.htm.

Agency for Healthcare Research and Quality (AHRQ). (2011, Apr 28). 2009 national healthcare disparities report. AHRQ publication no. 10-0004. Rockville (MD): AHRQ. Also available from: http://www.ahrq.gov/qual/qrdr09.htm

Agency for Healthcare Research and Quality (AHRQ). (2010). *National healthcare quality and disparities reports: NHQDRnet.* http://nhqrnet.ahrq.gov/nhqrdr/jsp/nhqrdr.jsp (accessed November 29, 2010).

Agency for Healthcare Research and Quality. (2000). Addressing racial and ethnic disparities in health care fact sheet. AHRQ Publication No. 00-PO41, Rockville, MD. http://www.ahrq.gov/research/disparit.htm

Alabama Department of Public Health (2011). , Health Disparities Status Report 2010. Retrieved from http://www.adph.org/minorityhealth/assets/DraftStatePlanEliminateDisparities.pdf

Alabama Department of Public Health, Health Disparities Advisory Council & the Minority Health Advisory Council. (2008, October). A Preliminary State Plan of Action to Reduce and Eliminate Health Disparities in Alabama (pp. 1-84). Montgomery, AL.

Alabama Immigration Law, HB 56 Alabama State Legislature. Latin America News Dispatch. Beason-Hammon Alabama Taxpayer and Citizen Protection Act. **Friday**, July 12th http://latindispatch.com/

Aoki, K. (2007). Distributive and syncretic motives in intellectual property law (with special reference to coercion, agency, and development). *UC Davis Law Review*, 40(30), 719–801. Available at: http://lawreview.law.ucdavis.edu/issues/Vol40/Issue3/DavisVol40No3_Aoki.pdf (accessed 21 December 2008).

Alford, D. (2012). *HeLa cells and unjust enrichment in the human body*. *Annals of Health Law. The Health Policy and Law Review of Loyola University Chicago School of Law*, *21*(1), 223–236.

Allen, T. W. (1994). *The invention of the White race* (Vol. 1). London and New York: Verso.

Allen, T. W. (1997). *The invention of the White race* (Vol. 2). London and New York: Verso.

Allen-Smith, J. E., Wimberley, R. C., & Morris, L. V. (2000). America's forgotten people and places: Ending the legacy of poverty in the rural south. *Journal of Agricultural and Applied Economics,* 32(2), 319–329.

Anderson, L. A., & Dedrick, R. F. (1990). Development of the Trust in Physician Scale: A measure to assess interpersonal trust in patient-physician relationships. *Psychological Reports*, *67*(3f), 1091–1100.

Andersen, R. M. (1968). A behavioral model of families' use of health services. Research Series No. 25. Chicago: Center for Health Administration Studies, University of Chicago.

Antai-Otong, B. (2003). *Psychiatric nursing: Biological and behavioral concepts.* New York: Thomson-Delmar.

Awara, M., & Fasey, C. (2008). Is spirituality worth exploring in psychiatric out-patient clinics? *Journal of Mental Health* 17,183-91.

Bates, B. R., & Harris, T. M. (2004, August). The Tuskegee study of untreated syphilis and public perceptions of biomedical research: A focus group study. *Journal of National Medical Association, 96*(8), 1054–1064.

Bayer, R., Gostin, L. O., Jennings, B., & Steinbock, B. (2007). *Public health ethics: Theory, policy, and practice.* New York: Oxford University Press

Beck, A. X, Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *American Journal of Psychiatry, 147,* 190–195.

Benson, J. (1998, Spring). Developing a strong program of construct validation: A test anxiety example. *Educational Measurement: Issues and Practice, 17*(1), 10–17.

Bloche, M. G. (2001). Race and discretion in American medicine. *Yale Journal of Health Policy Law & Ethics, 1*, 95.

Bonczar, T. P. (2003). *Prevalence of imprisonment in the U.S.pPopulation, 1974–2001*. Bureau of Justice Statistics Special Report, NCJ 197976.

Boucher, D., & Kelly, P. (Eds.). (1994). *The social contract from Hobbes to Rawls*. New York: Routledge.

Bowlby, J. (1969). *Attachment and loss: Vol.1. Attachment.* New York: Basic Books.

Boyas, J., & Valera, P. A. (2011). Determinants of trust in medical personnel. *Hispanic Health Care International*, 9(3), 144–152.

Braithwaite, R., James, G., & De La Rosa, M. (2011). The southern male placebo study: The good, the bad, and the ugly. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. 59–67). New York: Lexington Books.

Braithwaite, V. (2004, March). Collective hope. *The Annals of the American Academy, 592*(186), 6–15. DOI: 10.1177/0002716203262049

Brady, K., Pearlstein T., Asnis, G. M., Baker, D., Rothbaum, B., Sikes, C. R., & Farfel, G. M., (2000). Efficacy and safety of sertraline treatment of posttraumatic stress disorder: A randomized controlled trial. *Journal of the American Medical Association,* (283), 1837–1844.

Brady, M. J., Cella D. F., Mo, F., Bonomi, A. E., Tulsky, D. S., Lloyd, S. R., Deasy, S., Cobleigh M., & Shiomoto, G. (1997). Reliability and validity of the Functional Assessment of Cancer Therapy-Breast (FACT-B) quality of life instrument. *Journal of Clinical Oncology*, 15, 974–986.

Brandt A. (1978). Racism and research: the case of TSUS. The Hastings Center Report, 8, 21–29.

Braveman P. (2011). Accumulating knowledge on the social determinants of health and infectious disease. Public Health Rep. 2011; 126(Suppl 3):28–30.

Brown, P., & Flores R. (2011). Making normative structures visible: The British National Health Service and the Hospice Movement as signifiers of compassion and hope. *Acta Sociologica, 54,* 61–75.

Brown v. Board of Education, 347 U.S. 483 (1954).

Bullard, R. D., & Wright, B. (2012). *The wrong complexion for protection: How the government response to natural disasters endangers African American communities.* New York: New York University Press.

Bundrys, G. (2010). *Unequal health: How inequality contributes to health or illness* (2nd ed.). New York: Rowman & Littlefield Publishers.

Beyea, S. C. (1991). Factors influencing adults' participation in health enhancing activities (Doctoral Dissertation, Boston College, 1991). *Dissertations Abstracts International,* B52/06.

Boyas, J., & Valera, P.A.(2011). Determinants of Trust in Medical Personnel. *Hispanic Health Care International*, *9*(3), 144–152.

Byrd, W. M., & Clayton, L. (2000). *An American health dilemma. Volume I*. New York: Routledge.

Byrd, W. M., & Clayton, L. A. (2001, March). Race, medicine, and health care in the United States: A historical survey. *Journal of the National Medical Association, 93*(3) (SUPPL), 11S-34S.

Byrd, W. M., & Clayton, L. (2002). *An American health dilemma*. *Volume II*. New York: Routledge.

Calhoun, C. (1995). *Critical social theory: culture, history, and the challenge of difference*. New York: Wiley-Blackwell.

Caldwell, C., Davis, B., & Devine, J. A. (2009). Trust, faith, and betrayal: Insights from management for the wise believer. *Journal of Business Ethics, 89*(1), 103–114.

Campbell, A. (1995). Health as liberation: Medicine, theology, and the quest for justice. Cleveland, OH: The Pilgrim Press.

Carson, E. A., & Sabol, William J., (2012, December). Prisoners in 2011(pp. 1–34). Washington, DC: US Dept. of Justice Bureau of Justice Statistics, DNCJ239808.

Caterinicchio, R. P. (1979). Testing plausible path models of interpersonal trust in patient-physician treatment relationships. Social Science and Medicine, 13A, 81–99.

CDC Health Disparities and Inequalities Report—United States. (2011). MMWR Morbidity Mortality Weekly Report. 2011; 60(Supplement), 1–116.

Centers for Disease Control and Prevention (US), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Establishing a holistic framework to reduce inequities in HIV, viral hepatitis, STDs, and tuberculosis in the United States. Atlanta, GA: CDC; 2010. [cited 2011 Mar 10]. Also available from: URL: http://www.cdc.gov/socialdeterminants.

Centers for Disease Control and Prevention (US). HIV surveillance report, 2009, volume 21, February 2011. [2011 Mar 28]. Available from: URL: http://www.cdc.gov/hiv/topics/surveillance/resources/reports.

Chambon, A., Irving, A., & Epstein, L. (1999). *Reading Foucault for social work*. New York: Columbia University Press.

Cheavens, J. S., Feldman, D. B., Gum, A., Michael, S. T., & Snyder, C. R. (2006). Hope therapy in a community sample: A pilot investigation. *Social Indicators Research, 77,* 61–78.

Clark, R., Anderson, N., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*, 805–816.

Constitution of the World Health Organization. (1948, November) *American Journal of Public Health Nations Health*. *36*(11), 1315–1323.

Corbie-Smith, T. S. B., Williams, M. V., & Moody-Ayers, S. (1999, September). Attitudes and beliefs of African Americans toward participation in Medical Research. *Journal of General Internal Medicine, 14,* 537–546.

Cronbach, L. (1971). Test validation. In R. L. Thorndike (Ed.), *Educational measurement* (2nd ed.). Washington, DC: American Council on Education.

Cronbach, L., & Meehl, P. (1955). Construct validity of psychological test. *Psychological Bulletin, 52*, 281–302.

Cousins, N. (1974, December 14). Hope and practical realities. *Saturday Review/World. An Inventory of Hope* (Special Issue), 4–5.

Davidson, P., Andersen, R., Wyn, R. & Brown, E. R. (2004, Spring). A framework for evaluating safety-net and other community-level factors on access for low-income populations. Inquiry, 41, 21–38.

Dean, H. D., & Fenton K. A. (2010). Addressing social determinants of health in the prevention and control of HIV/AIDS, viral hepatitis, sexually transmitted infections, and tuberculosis. Public Health Rep. 2010; 125(Suppl 4), 1–5.

Del Vecchio Good, M. J., Good, B. J., Schaffer, C., & Lind, S. E. (1990). American oncology and the discourse on hope. *Culture, Medicine and Psychiatry*, *14*(1), 59–79.

Dollard, J. (1989). *Caste and class in a southern town*. Madison, WI: University of Wisconsin Press.

Du Bois, W. E. B. (1899). *The Philadelphia negro: A social study*. Philadelphia: University of Pennsylvania.

Du Bois, W. E. B. (1903). *The souls of black folk*. Oxford: Oxford University Press.

Dubree, M., & Vogelpohl, R. (1980). When hope dies–so might the patient. *American Journal of Nursing, 80*(11), 2046–2049.

Dufault, K., & Martocchio, B. (1985). Hope: Its spheres and dimensions. *Nursing Clinics of North America, 20,* 379–391.

Duggleby W., Hicks D., Nekolaichuk C., Holtslander L., Williams A., Chambers T., & Eby J. (2012). Hope, older adults, and chronic illness: A metasynthesis of qualitative research. *Journal of Advanced Nursing, 68*, 1211–1223.

Dunn, S.L. (2005). Hopelessness as a response to physical illness. *Journal of Nursing Scholarship, 37*,148–155.

Elders, M. J. (2011). The search for the legacy of the USPHS syphilis study at Tuskegee. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee*. New York: Lexington Books**.**

Eliott, J., & Olver, I. (2002). The discursive properties of hope: a qualitative analysis of cancer patients' speech. *Qualitative Health Research, 12* (2), 173–193.

Eliott, J., & Olver, I. (2007). Hope and hoping in the talk of dying cancer patients. *Social Science and Medicine, 64*(1), 138–149.

Eliott, J. A., & Olver, I. N. (2009). Hope, life, and death: a qualitative analysis of dying cancer patients' talk about hope. *Death Studies*, *33*(7), 609–638.

Endicott, J., Nee, J., Harrison, W., & Blumenthal, R. (1993). Quality of Life Enjoyment and Satisfaction Questionnaire: A new measure. *Psychopharmacology Bulletin, 29(*2), 321–326.

Endicott, J., Nee, J., Yang, R., & Wohlberg, C. (2006). Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire (PQ-LES-Q): Reliability and validity. *Journal of American Academy of Child Adolescent Psychiatry, 45*(4), 401–407.

Erikson, E. (1963). *Childhood and society* (2nd ed.) New York: W.W. Norton.

Erikson, E. H. (1964). *Insight and responsibility*. New York: W. W. Norton.

Everson, S. A., Kaplan, G. A., Goldberg, D. E., & Salonen, J. T. (2000). Hypertension incidence is predicted by high levels of hopelessness in Finnish men. Hypertension, 35, 561–567.

Falk, W. W., Talley, C. R., & Rankin, B. H. (1993). Life in the forgotten south: The Black Belt. In T. A. Lyson & W. W. Falk (Eds.), *Forgotten places: Uneven development in rural America* (pp. 53–75). Lawrence, KS: University Press of Kansas.

Fanon, F. (1963). *The wretched of the earth*. Farrington, C., translator. New York: Grove Press.

Farmer, P. E. (1994). *Pathologies of power: Health, human rights, and the new war on the poor*. (2005). CA: University of California Press.

Farran, C. J., Herth, K. A., & Popovich, J. M. (1995). *Hope and hopelessness: Critical, clinical, constructs.* Thousand Oaks, CA: Sage.

Final Report of TSUS Legacy Committee. (1996, May 20). Retrieved from .hsl.virginia.edu/historical/medical_history/bad_blood/report.cfm

Fiscella, K., Franks, P., Gold, M. R., & Clancy, C. M. (2000). Inequality in quality: Addressing socioeconomic, racial, and ethnic disparities in health care. *Journal of the American Medical Association, 283,* 2579–2584.

Fitzgerald, R. (1979). *The sources of hope.* Rushcutters Bay, Australia: Pergamon Press.

Frankl, V. (1992). *Man's search for meaning: An introduction to logotherapy* (4th ed.). Boston, MA: Beacon's Press.

Freehling, W. W. (1972, February). The founding fathers and slavery. *The American Historical Review*, *77*(1), 81–93.

Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health, 100*(Suppl 1), S30–35. [PubMed: 20147679]

Ford, C. L., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: praxis for antiracism research. *Social Science Medicine, 71*(8), 1390–98. [PubMed: 20822840]

Freeman, R. B. (1996). Why do so many young American men commit crimes and what might we do about it? *Journal of Economic Perspectives*, 10(1), 25–42.

Freudenberg N. (2002). Adverse effects of U.S. jail and prison policies on the health and well-being of women of color. *American Journal of Public Health, 92,* 1895–1899.

Galbraith, J. K., Jane Jacobs, J., & Bernie, L. (2008, January). Five great Massey lectures: Recovered classics from five great thinkers. ON: House of Anansi.

Galloway, F. (2011, April). LaVeist Addresses ASU 9th SIRC Conference**.**

Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research VI, 3*(23–9), 109–134.

Galtung, J. (1990). Cultural violence. *Journal of Peace Research 27*(3). New York: Sage Publications.

Gamble, V. (1993). A legacy of distrust: African Americans and medical research. *American Journal of Preventive Medicine*, Supplement 9, 35–38.

Gamble, V. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health, 87*, 1773–1778.

Gamble, V., & Fletcher, J. (1996). Final report of the Tuskegee Syphilis Study Legacy Committee. Atlanta, GA: Centers for Disease Control and Prevention.

Geiger, H. J. (2003). Racial and ethnic disparities in diagnosis and treatment: A review of the evidence and a consideration of causes. In B. Smedley, A. Stith, & A. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (pp. 417–454). Washington, DC: The National Academies Press.

Geronimus, A. T., Bound**,** J., & Waidmann, T. A. (1999, June). Poverty, time, and place: Variation in excess mortality across selected United States populations. *Journal of Epidemiology and Community Health, 53*(6), 325–334.

Gibson, J. S. (1941, January). The Alabama Black Belt: Its geographic status. *Economic Geography, 17*(1), 1–23.

Gill, J. M. (2004). The structure of primary care: Framing a big picture. *Family Medicine,* 36(1), 65–68.

Goold, S. D. (2002). Trust, distrust and trustworthiness. *Journal of General Internal Medicine, 17*(1), 79–81.

Gray F. D. (1998). *The Tuskegee Syphilis Study*. Alabama: Montgomery, New South Books.

Groopman, J. (2004). *The anatomy of hope*. New York: Random House.

Halbert, C., Armstrong, K., Gandy, O. H., & Shaker, L. (2006). Racial differences in trust in health care providers. *Archives of Internal Medicine*, 166(8), 896–901. Retrieved from EBSCO*Host*.

Hall, M.A., Camacho F., Dugan, E., & Balkrishnan R. (2002). Trust in the medical profession: conceptual and measurement issues. *Health Service Research, 37*, 1419–1439.

Hall, M. A., Dugan, E., Zheng, B., & Mishra, A. K. (2001). Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *Milbank Quarterly, 79*, 613–639.

Hall, M. A., Zheng, B., Dugan, E., Camacho, F., Kidd, K. E., Mishra, A., & Balkrishnan, R. (2002). Measuring patients trust in their primary care providers. *Medical Care Research and Review, 59*, 293–318.

Hall, S. R., McDavid, H. I., Harrison, K., Telfair Sharpe T., Lin L. S., Dean H. D. (2011). Identifying the impact of social determinants of health on disease rates using correlation analysis of area-based summary information. Public Health Rep. 126(Suppl 3), 70–80.

Haney, C., & Zimbardo, P. (1998, July). The past and future of U.S. prison policy: Twenty-five years after the Stanford prison experiment, *American Psychologist*, *53*(7), 709–727.

Hannaford, I. (1996). *Race: The history of an idea in the West.* Baltimore: Johns Hopkins University Press.

Hare, K. (2010, August 24). State's Black Belt remains troubled. *Montgomery Advertiser,* 5a.

Harnam, N., Wyrwich, K. W., Revicki, D., Locklear, J. C., & Endicott, J. (2011). The measurement of health-related quality of life in a population with generalized anxiety disorder – Findings from the QUEST Study, 199–218.

Harris, Y., Gorelick, P. H., Samuels, P., & Bempong, I. (1996). Why African Americans may not be participating in clinical trials. *Journal of the National Medical Association, 88(*10), 630–634.

Heller J. (1972, July). Syphilis victims in U.S. study went untreated for 40 years. New York Times, 26, A1, A8.

Henderson, A., Phillips., & Will, J. (2005). Does religiosity affect perceptions of racism in the New South? *Sociation Today, 3*(2), 1–10. Retrieved from http://www.ncsociology.org/sociationtoday/v32/religion.htm 8/25/2006

Hendricks, C. S. (1998a). Perceptual determinants of early adolescent health promoting behaviors: Model development. *Journal of Theory Construction and Testing, 2*(1), 13–22.

Hendricks, C. S., Hoffman, H., Robertson-Laxton, Tavakoli, A. Mathis, D., Hackett, D., & Byrd, L. (2000). Hope as a predictor of health promoting behavior among rural southern early adolescents. *Journal of Multicultural Nursing and Health, 6*(3), 5–11.

Herth, K. (1990). Fostering hope in terminally-ill people. *Journal of Advanced Nursing, 15*(11), 1250–1259.

Herth, K., & Cutcliffe, J. (2002). The concept of hope in nursing 4: Hope and gerontological nursing. *British Journal of Nursing, 11*(17), 1148–1156.

Herth, K. A., & Cutcliffe, J. R. (2002). The concept of hope in nursing 6: Research/education/ policy/practice. *British Journal of Nursing, 11*(21), 1404–1411.

Hinds, P. S. (1984). Inducing a definition of 'hope' through the use of grounded theory methodology. *Journal of Advanced Nursing*, *9*(4), 357–362.

Ho, K. (2007, September). Structural violence as a human rights violation. Essex Human Rights Review, 4(2), 1–17.

Holleman, H., McChesney, R. W., Bellamy, F. J., & Jonna, R. (2009, June). The penal state in an age of crisis. *Monthly Review, 61*(2), 1–17.

Huddleston,W., & Marlowe, D. B. (2011, July). Painting the current picture: A national report on drug courts and other problem solving court programs in the United States. Alexandria, VA: National Drug Court Institute, NCJ 235776, 1-68.

Hupcey, J. E., & Miller, J. (2005). Community dwelling adults' perception of interpersonal trust vs. trust in health care providers. *Journal of Clinical Nursing, 15*, 1132–1139.

Hupcey, J. E., Penrod, J., Morse J. M., & Mitcham, C. (2001). An exploration and advancement of the concept of trust. *Journal of Advanced Nursing, 36*, 282–293.

Institute of Medicine (IOM). (1988). The future of public health. Washington, DC: National Academy Press.

Institute of Medicine. (1999). *The unequal burden of cancer: An assessment of NIH research and programs for ethnic minorities and the medically underserved*. Washington, DC: National Academies Press.

Institute of Medicine. (1999). *To err is human. Building a safer health system.* Washington, DC: The National Academies Press. (http://www.nap.edu).

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press. (http://www.nap.edu).

Institute of Medicine. (2003). *Unequal treatment*. Washington, DC: The National Academies Press. (http://www.nap.edu).

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press

Institute of Medicine. (2010). For the public's health: the role of measurement in action and accountability. Washington: The National Academies Press. [cited 2011 Mar 10]. Also available from: URL: http://iom.edu/Reports/2010/For-the-Publics-Health-The-Role-of-Measurement-in-Action-and-Accountability.aspx.

Institute of Medicine. (2011). Leading health indicators for Healthy People 2020—letter report. Washington: National Academies Press. [cited 2011 Apr 28]. Also available from: URL: http://www.iom.edu/~/media/Files/Report%20Files/2011/Leading-Health-Indicators-for-Healthy-People-2020/Leading%20Health%20Indicators%202011%20Report%20Brief.pdf

Institute of Medicine. (2011). Leading health indicators for Healthy People 2020—Letter Report. [cited 2011 Mar 28]. Available from: URL: http://www.iom.edu/Reports/2011/Leading-Health-Indicators-for-Healthy-People-2020.aspx

Johns, J. L. (1996). A concept analysis of trust. *Journal of Advanced Nursing, 24*, 76–83.

Jones, C., LaVeist, T., & Lillie-Blanton, M. (1991). '**Race**' in epidemiologic literature: An examination of the *American Journal of Epidemiology*, 1921–1990. *American Journal of Epidemiology*, *134*, 1079–1084.

Jones, J. (2011). Of thanks and forgiveness. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. 19–27). New York: Lexington Books.

Jones, J. H. (1993). *Bad blood: The Tuskegee syphilis experiment.* New York: Free Press.

Kao, A. C., Green, D. C., Zaslavsky, A. M., Koplan, J. P., & Cleary, P. D. (1998 November 18). The relationship between method of physician payment and patient trust. *Journal of the American Medical Association*, *280*(19), 1708–1714.

Katz. R. V. (2011). Introduction: Information stream of the USPHS syphilis study at Tuskegee "legacy," 1972–2010. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. xxi-xli). New York: Lexington Books.

Katz, R. V., Green, L., Kressin, N. R., et al. (2009). Exploring the "legacy" of the Tuskegee syphilis study: A follow-up study from the Tuskegee Legacy Project. *Journal of the National Medical Association, 101*(2), 179–183.

Katz, R.V., Green, L., Kressin, N.R., et al. (2008). The legacy of the Tuskegee syphilis study: Its impact on willingness to participate in biomedical research studies. *Health Care Poor Underserved*, *19*, 1169–1181.

Kee, H. W., & Knox, R. E. (1970). Conceptual and methodological considerations in the study of trust. *Journal of Conflict Resolution, 14*, 357–366.

King, M. L. (1963). Letter from Birmingham Jail. Historical Text Archive. *http://historicaltextarchive.com/sections.php?op=viewarticle&artid=40*

Kodish, E., & Post, S. G. (1995). Oncology and hope. *Journal of Clinical Oncology, 13*(7), 1817–1822.

Kovner, A. R., & Knickman, J. R. (2011). *Health care delivery in the United States* (10th ed.). New York: Springer.

Krieger, N., Chen, J. T., & Ebel, G. (1997). Can we monitor socioeconomic inequalities in health? A survey of U.S. health departments' data collection and reporting practices. Public Health Report, 112, 481–491.

LaVeist, T. (2002). Race, ethnicity, and health: A public health reader. San Francisco, CA: Jossey-Bass Publishers.

LaVeist, T. A. (2005). *Minority populations and health: An introduction to health disparities in the United States.* San Francisco, CA: Jossey-Bass Publishers.

LaVeist, T. A., Gaskin, D. J., & Richard, P. (2009). The economic burden of healthcare inequalities in the United States (pp. 1–16). Washington, DC: Joint Center for Political and Economic Studies.

LaVeist, T. A., Nickerson, K. J., & Bowie, J. V. (2000). Attitudes about racism, medical mistrust and satisfaction with care among African American and white cardiac patients. *Medical Care Research and Review*, 57, 146–161.

Lazarus, R. S. (1999). Hope: An emotion and a vital coping resource against despair. *Social Research*, 66, 653–678

Lederer, S. E. (1995). *Subjected to science: Human experimentation in America before the second world war*. Baltimore: John Hopkins

Lee v. Macon County Board of Education, 267 F. Supp. 458 (M.D. Ala. 1967).

Lewis, R. (1995, Fall). A conceptual framework for understanding contemporary race relations in the United States. *Journal of Intergroup Relations, XXII*(3), 18–27.

Lipovcan, L. K., Prizmic, L. Z., & Zganec N. (2004). Quality of life, life satisfaction and happiness in shift- and nonshift-workers. *Revista de Saúde Publica, 38,* 3–10.

Livingston, J. N., & Nahimana, C. (2006). Problem child or problem context: An ecological approach to young Black males. Reclaiming Children & Youth, 14, 209–214.

Lynn-McHale, D. J., & Deatrick, J. A. (2000). Trust between family and healthcare provider. *Journal of Family Nursing*, 6, 210–230.

Marks, J. (1995). *Human biodiversity: Genes, race, and history.* New York: Aldine de Gruyter.

Marsiglia, F. F., Kulis, S., Garcia Perez, H., & Bermudez-Parsai, M. (2011, February). Hopelessness, family stress, and depression among Mexican-heritage mothers in the southwest. Health Social Work, *36*(1), 7–18.

Mattis, J. S., Fontenot, D. L., Hatcher-Kay, C. A., Grayman, N. A., & Beale, R. L. (2004). Religiosity, optimism, and pessimism among African Americans. *Journal of Black Psychology*, *30*, 187–207.

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995). An integrative model of organization trust. *Academy of Management Review*, *20*, 709–733.

McCabe, R. V. (1999, Fall). The meaning of "born of water and the spirit" In John 3:5. *Detroit Baptist Seminary Journal, 4, 85–107.*

McCarthy, D., How, S. K. H., Schoen, C., Cantor, J. C., & Belloff, D. (2009, October). Aiming higher results from a state scorecard on health system performance. Washington, DC: The Commonwealth Fund.

McGeer, V. (2008, June). Trust, hope and empowerment. *Australasian Journal of Philosophy*, *86*(2), 237–254.

Mechanic, D. (1998). Public trust and initiatives for new health care partnerships. *Milbank Quarterly*, *76*(2), 281–302.

Meize-Grochowski, R. (1984). An analysis of the concept of trust. *Journal of Advanced Nursing*, *9*, 563–572.

Messick, S. (1989). Validity. In R. Linn (Ed.), *Educational measurement* (3rd ed.). Washington DC: American Council on Education.

Miceli, M., & Cristiano Castelfranchi, C. (2010) Hope: The power of wish and possibility *Theory and Psychology, 20*(2), 251–276.

Mick, E., Faraone, S. V., Spencer, T., Zhang, H. F., & Biederman, J. (2008). Assessing the validity of the Quality of Life Enjoyment and Satisfaction Questionnaire Short Form in adults with ADHD. *Journal of Attention Disorders, 11*(4), 504–509.

Miller, J. F. (1992). *Coping with chronic illness: Overcoming powerlessness* (2nd ed.). Philadelphia: F.A. Davis Company.

Miller, J. F. (2000). *Coping with chronic illness: Overcoming powerlessness* (3rd ed.). Philadelphia: F.A. Davis Company.

MMWR Weekly. (2000, February 11). Age-specific excess deaths associated with stroke among racial/ethnic minority populations – United States. 1997 49(05), 94–97.

MMWR Weekly. (1986, February 28). Perspectives in Disease Prevention and Health Promotion. Report of the Secretary's Task Force on Black and Minority Health. 35(8), 109-112.

Mokdad, A. H., Marks, J. S., Stroup, D. F., & Gerberding, J. L. (2004, March 10). Actual Causes of Death in the United States, 2000. *JAMA*, *291*(10), 1238–1245.

Morbidity and Mortality Weekly Report Supplement. (2011, January 14). CDC Health Disparities and Inequalities Report — United States, 2011. U.S. Department of Health and Human Services. Centers for Disease and Prevention. 1-116.

Morial, M. (2012, March 21). National Urban League President and CEO Marc H. Morial Demands Justice in the Death of Trayvon Martin. National Urban League http://nul.iamempowered.com/

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious involvement, spirituality and medicine: Implications for clinical practice. *Mayo Clinic Proceedings*, *76*(12), 1225–1235.

Myrdal, G. (1944). *An American dilemma: The negro problem and modern democracy*. New York: Harper & Brothers.

National Economic & Social Rights Initiative Human Needs. (2010, October 10). People of color and the human right to health care: A perspective on the federal health reform law (pp. 1–4). Retrieved from: *www.nesri.org/*

National Economic & Social Rights Initiative Human Needs. (2010, October 10). People of color and the human right to health care: A perspective on the federal health reform law (pp. 1–4). Retrieved from: *www.nesri.org/*

National Economic & Social Rights Initiative. (2008, January). Human Needs Human Rights Info Sheet no. 1 Human Right to Health 1–2. Retrieved: *www.nesri.org/*

Nekolaichuk, C. L., Jevne, R. F., & Maguire, T. O. (1999) Structuring the meaning of hope in health and illness. *Social Science & Medicine, 48*, 591–605.

Nelson, M. D., Roberts, M. A., & Synder, C. R. (1996). Early adolescents exposed to violence hope and vulnerability to victimization. *American Orthropsychiatric Association*, *66*(3), 346–353.

Obama, B. (2006). The audacity of hope: Thoughts on reclaiming the American dream. New York: Crown.

Obama, B. (2007). My cure for an ailing system. *Modern Healthcare*, 37(47), 21. Retrieved from EBSCO*host*.

Olansky, S., Simpson, L., & Schuman, S. (1954, July). Untreated syphilis in the male negro: Environmental factors in the Tuskegee study of untreated syphilis. *Public Health Reports, 69*(7), 691–698.

Omi, M. A., & Winant, H. (1994). *Racial formation in the United States* (2nd ed.). New York: Routledge.

O'Neil, E. J. (2009, Autumn). Race/ethnicity: Race and the global politics of health inequity. *Multidisciplinary Global Contexts*, *3*(1), 115–138.

Orne, M. (1968). On the nature of effective hope. *International Journal of Psychiatry*, *5*, 403-410.

Paris, P. J. (2012). An ethical inquiry into the USPHS of Untreated Syphilis in the Male Negro, 1932–1972. [publication forth coming]

Paris, P. J. (1985). *The social teaching of the black churches*. Minneapolis: Fortress Press.

Pearson, S. D., & Raeke, L. H. (2000). Patients' trust in physicians: Many theories, few measures, and little data. *Journal of General Internal Medicine*, *15*(7), 509–513.

Pettit, P. (2004). Hope and its place in mind. *The Annals of the American Academy of Political and Social Science*, *592*, 152–165.

Phillips, S. P. (2011). Including gender in public health research. Public Health Report, 126(Suppl 3), 16–21.

Phillips, U.B. (1905, June). The economic cost of slaveholding in the cotton belt. *Political Science Quarterly*, *20*(2), 257–275.

Pieterse, A. L., & Carter, R. T. (2007). An examination of the relationship between general life stress, racism-related stress, and psychological health among black men. *Journal of Counseling Psychology, 54,* 101–109. doi:10.1037/0022-0167.54.1.10

Pinn, V. W. (2011). From exclusion to inclusion: Participation in biomedical research and the legacy of the public health syphilis study at Tuskegee. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. 1–18). New York: Lexington Books**.**

Planas, R. (2011, June 10). Alabama passes country's toughest immigration law yet. Latin America News Dispatch. Retrieved http://latindispatch.com/

Polit, D., & Beck, C. T. (2004). *Nursing research. Principles and methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Polit, D., Beck, C., & Hungler, B. (2001). *Essentials of nursing research: Methods, appraisal, and utilization* (5th ed). Philadelphia: Lippincott.

Powell, W., Hammond, W. P., Derrick, M, D., Corbie-Smith, G. (2010, April). Psychosocial factors associated with routine health examination scheduling and receipt among African American men. *Journal National Medical Association, 102*(4), 276–289.

Prothrow-Stith, D. (1991). *Deadly consequences: How violence is destroying our teenage population, and a plan to begin solving the problem.* New York: HarperCollins.

Quesada, J., Laurie, K., Hart, L. K., & Bourgois, P. (2011, July). Structural vulnerability and health: Latino migrant laborers in the United States. *Medical Anthropology,* 30(4), 339–362.

Ramsey, T. R. (2012, December). The black church: Its origin, its operation and its objective. *The Christian Education Informer*. *A Journal of Christian Education, 65*(2), 2–56.

Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services, 36*, 651–677.

Raphael, D. (2004). Introduction to the social determinants of health. In D. Raphael (Ed.), *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholars' Press.

Raphael, S. (2006). The socioeconomic status of black males: The increasing importance of incarceration. *Public Policy and the Income Distribution*, 319–358.

Reif, S., Lowe, K. G., & Whetten, K. (2006, June). HIV infection and AIDS in the deep south. *American Journal of Public Health, 96*(6), 970-973.

Renwick, R., Brown, I., & Raphael, F. (1994). Quality of life: Linking a conceptual approach to service provision. *Journal of Developmental Disability*, *3,* 32–44.

Revicki, D. A., Brandenburg, N., Matza, L., Hornbrook, M. C., & Feeny, D. (2008). Health related quality of life and utilities in primary-care patients with generalized anxiety disorder. *Quality of Life Research, 17*(10), 1285–1294.

Riggins, E. (2011). The USPHS Study at Tuskegee: Rethinking the Horizons of Beneficence. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. 117–127). New York: Lexington Books.

Riverby, S. (2009). The infamous syphilis study and its legacy: Examining Tuskegee. North Carolina: The University of North Carolina.

Riverby, S. M. (2011). The Tuskegee syphilis study as a "Site of Memory". In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. 29– 40). New York: Lexington Books.

Robert Wood Johnson Foundation. (2010, July). A new way to talk about the social determinants of health. [cited 2011 Mar 28]. Available from: URL: http://www.rwjf.org/files/research/vpmessageguide20101029.pdf

Rosenfeld, B., Pessin, H., Lewis, C., Abbey, J., Olden, M., Sachs, E., & ... Breitbart, W. (2011). Assessing hopelessness in terminally ill cancer patients: Development of the Hopelessness Assessment in Illness Questionnaire. *Psychological Assessment*, *23*(2), 325–336.

Rossi, A., Rucci, P., Mauri, M., Maina, G., Pieraccini, F., Pallanti, S., & Endicott, J. (2005). Validity and reliability of the Italian version of the Quality of Life, Enjoyment and Satisfaction Questionnaire. *Quality of Life Research, 14*(10), 2323–2328.

Rousseau, D., Sitkin, M., Burt, R., & Camerer, C. (1998). Not so different after all: A cross-discipline view of trust. *Academy of Management Review*, *23*(3), 393–404.

Rubio, D., Berg-Weber, M. Tebb, S., Lee, E., & Rauch, S. (2003). Objectifying content validity: Conducting a content validity study I: Social work research. Social Work Research, 27(2), 94–104.

Ruffin, J. (2010). The science of eliminating health disparities: Embracing a new paradigm. *American Journal of Public Health*, 100, S8-S9.

Sabol, W. J., Minton, T. D., & Harrison, P. M. (2007). *Prison and Jail Inmates at Midyear 2006*. Washington, DC: Bureau of Justice Statistics.

Sadana, R., & Harper, S. (2011). Data systems linking social determinants of health with health outcomes: Advancing public goods to support research and evidence-based policy and programs. Public Health Report 126(Suppl 3):6–13.

Satcher, D. (2011). Tuskegee legacy: The role of the social determinants of health. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. 41–47). New York: Lexington Books.

Schechter, D., Endicott, J., & Nee, J. (2007). Quality of life of 'normal' controls: Association with lifetime history of mental illness. *Psychiatry Research, 152*(1), 45–54.

Shariff-Marco, S., Klassen, A. C., & Bowie, J. V. (2010). Racial/ethnic differences in self-reported racism and its association with cancer-related health behaviors. *American Journal of Public Health, 100*(2), 364–374.

Shavers V. L., Lynch, C. F., & Burmeister, L. F. (2002). Racial differences in factors that influence the willingness to participate in medical research studies. *Annals of Epidemiology* 12, 248–256.

Sin, N. L., Jacobs, K. M., & Lyubomirsky, S. (in press). House and happiness: A differential diagnosis. In L. L. Martin & T. Cascio (Eds.), *House and psychology*. New York: Wiley.

Smedley, A. (1999a). Race and the construction of human identity. *American Anthropologist, 100*, 690–702.

Smedley**,** A. (1999b). *Race in North America: Origin and evolution of a worldview* (2nd ed.). Boulder, CO: Westview Press.

Smedley, A. (2006). On the confusion of 'race' with biophysical diversity. *American Psychologist*, *61*(2), 180–181. doi:10.1037/0003-066X.61.2.180

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American Psychologist*, *60*(1), 16–26. doi:10.1037/0003-066X.60.1.16

Smedley, B. D., Stith, A. Y., et al. (Eds.). (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academy Press.

Smedley**,** B**.** D**.,** Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. (Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care)

Snyder, C. R. (1995). Conceptualizing, measuring, and nurturing hope. *Journal of Counseling and Development, 73,* 355–359.

Sokol, D. K. (2006). How the doctor's nose has shortened over time: a historical overview of the truth-telling debate in the doctor-patient relationship. *Journal of the Royal Society of Medicine*, *99*(12), 632–636.

Solo'rzano, D. (1998). Critical race theory, race and gender microaggressions, and the experience of Chicano and Chicano Scholars. *International Journal of Qualitative Studies in Education*, *11*,121–136.

Sousa, L., & Lyubomirsky, S. (2001). Life satisfaction. In J. Worell (Ed.), *Encylopedia of women and gender: Sex similarities and differences and the impact of society on gender* (Vol. 2, pp. 667–676). San Diego, CA: Academic Press.

Southern Poverty Law Center (SPLC). (2010). Effective discipline for student success: Reducing student and teacher dropout rates in Alabama (pp. 1–10). Montgomery, AL: Southern Poverty Law Center.

Spohn, C., & Holleran, D. (2000). The imprisonment penalty paid by young, unemployed black and Hispanic male offenders. *Criminology, 38*(1), 281–306.

Staff. (2011, June 9).Text of Alabama Immigration Law, HB 56**.** Latin America News Dispatch. Retrieved http://latindispatch.com/

Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist, 52*(6), 613–229.

Sternberg, R. J., Grigorenko, E. L., & Kidd, K. K. (2005). Intelligence, race, and genetics. *American Psychologist*, *60*(1), 46–59. doi:10.1037/0003-066X.60.1.46

Stephenson, C. (1991). The concept of hope revisited for nursing. *Journal of Advanced Nursing, 16*(12), 1456–1461.

Suitts, L., & Veasey, L. (2008). Realizing the American dream through education: High school dropouts, Alabama's number one education problem. The Southern Education Foundation (pp. 1–32). www.southerneducation.org. Retrieved from http://southerneducation.org/cmspages/getfile.aspx?guid=55088b45-1eaa-40d5-87aa-7c2ef9dceda0

Tatum, B. (1992, Spring). Talking about race, learning about racism: The application of racial identity development theory in the classroom. *Harvard Educational Review, 62*(1), 1–24.

Teranishi, R. T., & Briscoe, K., (2008, Winter). Contextualizing race: African American college choice in an evolving affirmation. *The Journal of Negro Education, 77*(1), 15–26.

The College Board. (2011). The educational experience of young men of color: A review of research. Pathways and Progress, 1–96. Retrieved from http://advocacy.collegeboard.org/sites/default/files/EEYMC-ResearchReport_0.pdf

The Schott Foundation for Public Education. (2012). Yes we can: The 2010 Schott 50 state report on black males and public education. 1–44. Retrieved from http://www.blackboysreport.org/bbreport.pdf

The Schott Foundation for Public Education. (2012). Given Half a Chance: The 2008 Schott 50 state report on public education and black males.1-18. Retrieved from http://www.blackboysreport.org/bbreport.pdf

The White House Office of the Press Secretary. (1997, May 16). Remarks by the President in Apology for Study Done in Tuskegee.

Thom, D. H., Ribisl, K. M., Stewart, A. L., & Luke, D. A. (1999a). Further validation and reliability testing of the Trust in Physician Scale: The Stanford trust study physicians. *Medical Care, 37*, 510–517.

Thom, D. H., Ribisl, K. M., Stewart, A. L., & Luke, D. A. (1999b). Further validation and reliability testing of the Trust in Physician Scale. *Medical Care, 37*, 510–517.

Thomas, S. B., Benjamin, G. C., Almario, D., & Lathan, M. J. (2006). Historical and current policy efforts to eliminate racial and ethnic health disparities in the United States: Future opportunities for public health education research. *Health Promotion Practice*, *7*(3), 324–330.

Thomas, S. B., Quinn, C. Q., Butler, J., Craig, S., Fryer, C. S., & Garza, M. A. (2011). Toward a fourth generation of disparities research to achieve health equity. *Annual Review of Public Health, 32*(1), 399–416.

Thomas Nagel, T. (2005, Spring). The problem of global justice. *Philosophy & Public Affairs*, *33*(2), 113-147.

Thompson, G. E., Mitchell, M., & Williams. F. (2006). Examining the health disparities plan of the national institute of health. Washington, DC: The National Academies Press.

Thorne, S. E., & C. A. Robinson. (1988). Reciprocal trust in health care relationships. *Journal of Advanced Nursing, 13*, 782–789.

Tong, R. (1998). *Feminist thought: A more comprehensive introduction* (2nd ed.). Denver, CO: Westview Press

Townsend, M. C. (2012). *Psychiatric mental health nursing: Concepts of care in evidence-based practice* (7th ed.). Philadelphia: F.A. Davis

Tripp-Re Lisa, T., Skemp, K. M., & Enslein, J. C. (2001). Cultural barriers to care: Inverting the problem. *Diabetes Spectrum, 14*(1), 13–22.

Trojan, L., & Yonge, O. (1993). Developing trusting, caring relationships: home care nurses and elderly clients. *Journal of Advanced Nursing, 18,* 1903–1910.

Tucker, C. M., Marsiske, M., Rice, K. G., Nielson, J., & Herman, K. (2011). Patient-centered culturally sensitive health care: Model testing and refinement. *Health Psychology*, *30*(3), 342–350. doi:10.1037/a0022967.

Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine). Washington, DC: National Academies Press.

United States Department of Health and Human Services (DHHS). (1975). *Secretary's Task Force on Black and Minority Health, Vol. I–VIII.* Washington, DC: U.S. Govt. Printing Office.

United States Department of Health and Human Services (DHHS). (2000). Healthy People 2010 (Vols. I–II). Washington, DC: Author.

United States Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Executive Summary. Retrieved from http://minority_health.hhs.gov/assets/pdf/checked/executive.pdf

United States Department of Health and Human Services (DHHS). (2011). Healthy People 2020. [cited 2011 Apr 28]. Available from: URL: http://www.healthypeople.gov/2020/default.aspx.

United States Department of Health and Human Services (DHHS). (2011). Healthy People 2020: Determinants of health. [2011 Mar 28]. Available from: http://www.healthypeople.gov/2020/about/DOHAbout.aspx

United States Department of Health and Human Services (DHHS). (2010). HHS action plan to reduce racial and ethnic health disparities. April 2010. [cited 2011 Apr 8]. Available from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

United States Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

United States Department of Health and Human Services (DHHS). (1986). Report of the Secretary's Task Force on Black and Minority Health. Volume II: Crosscutting Issues in Minority Health: Perspectives on National Health Data for Minorities, Minority Access to Health Care, Health Education and Information, Minority and other Professionals Serving Minority Communities. Washington, DC: U.S. Department of Health and Human Services.

United States Department of Health and Human Services (DHHS). (1975). *Secretary's Task Force on Black and Minority Health, Vol. I–VIII.* Washington, DC: U.S. Government Printing Office.

United States Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Executive Summary. Retrieved from http://minority_health.hhs.gov/assets/pdf/checked/executive.pdf

Vocino, T. (2011, July). Counties in crisis, assessing quality of life in Alabama (pp. 1–94). Montgomery, AL: Alabama State University Center for Leadership and Public Policy.

Warren, R. C. (2011). Healing the sin-sick soul: Reflections on the syphilis study. In R. V. Katz & R. C. Warren (Eds.), *The search for the legacy of the USPHS syphilis study at Tuskegee* (pp. 141–151). New York: Lexington Books.

Washington, H. A. (2006). *Medical apartheid: The dark history of medical experimentation on black Americans from colonial times to the present.* New York: Random House.

Watson, P. J., Morris, R. J., & Hood, R. W. (1988). Sin and self-functioning, Part 1: Grace, guilt, and self-consciousness. Journal of Psychology and Theology, 16, 254–269.

Wendler, D, Kington, R., Madans, J., Wye, G. V., Christ-Schmidt, H, et al. (2006) Are racial and ethnic minorities less willing to participate in health research? PLoS Med 3(2): 0201-0210. doi:10.1371/journal.pmed.0030019

Werner, E., & R. Smith. (1992). *Overcoming the odds: High-risk children from birth to adulthood.* New York: Cornell University Press.

Western, B., & Pettit, B. (2010, Summer). Incarceration and social inequality, Dædalus. Cambridge, MA: American Academy of Arts and Sciences, p. 8-19.

White, R. M. (2005). Misinformation and misbeliefs in the Tuskegee Study of Untreated Syphilis fuel mistrust in the healthcare system. *Journal of National Medical Association, 97*, 1566–1573. [PubMed: 16334509]

Whitkin, S. L., & Gottschalk, S. (1998, June), Alternative criteria for theory evaluation. *Social Service Review, 62*(2), 211-224.

Wiley-Blackwell (2010, May 15). New research reveals Hurricane Katrina’s impact on ecological and human health. *Science Daily*. Retrieved May 27, 2012, from http://www.sciencedaily.com /releases/2010/05/100513212429.htm

Wilkins, R., Berthelot, J. M., & Ng, E. (2002). Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996. *Health Representative*, 13(supplement), 1–28.

Williams, D., Lavisso-Mourey, R., & Warren, R. (1994, January-February). The concept of race and health status in America. *Public Health Reports, 109*(1), 26–41.

Williams, D. R., McClellan, M. B., & Rivlin, A. M. (2010). Beyond the affordable care act: Achieving real improvements in Americans’ health. *Health Affairs, 29*(8), 1481–1488.

Wimberley, D. W. (2008, Fall). Mortality patterns in the southern black belt: Regional and racial disparities. *Sociation Today, 6*(2), 1-18.

Wimberley, D. W. (2010). Quality of life trends in the southern Black Belt, 1980–2005: a research note. *Journal of Rural Social Sciences*, *25*(1), 103-118.

Wimberley, R. C., Morris, L. V., & Woolley, D. P. (2001). *The black belt databook.* Lexington, KY: TVA Rural Studies.

World Health Organization. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June–22 July 1946; signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. [cited 2011 Mar 28]. Available from: URL: http://www.who.int/suggestions/faq/en.

World Health Organization, Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. CSDH final report. Geneva: WHO.

Wright, E. O., Rogers, J. [Forthcoming, 2010]. American society: How it actually works. Available at http://www.rebeldemule.org/foro/biblioteca/tema10516.html

Young, M. A., Fogg, L. F., Scheftner, W., Fawcett, J., Akiskal, H., & Maser, J. (1996). Stable trait components of hopelessness: Baseline and sensitivity to depression. *Journal of Abnormal Psychology 10*(2), 155–165.

Zekeri, A. A. (1996, September 20). Community action in Alabama's black belt timber-dependent communities. *Social Indicators Research*, 39, 203–228.

Zekeri, A. A. (2002). Poverty: A barrier to comprehensive rural community development in Black Belt Counties of Alabama. In N. Baharani, R. Zabawa, W. Hill & A. Parks (Eds), *Rural development and a changing USDA* (Tuskegee University), 63–65.

Zyphur, M. J. (2006). On the complexity of race. *American Psychologist*, *61*, 179–180.

APPENDIX A

INFORMATION LETTER

[illegible]
[illegible]
[illegible]
from 4/21/10 [illegible] 4/20/11
Protocol # 10-113 EP 1004

AUBURN UNIVERSITY

COLLEGE OF EDUCATION

EDUCATIONAL FOUNDATIONS, LEADERSHIP AND TECHNOLOGY

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)

INFORMATION LETTER
for a Research Study entitled
"The Relationship of Trust in the Health Care System and Hope to Quality of Life Satisfaction Among Adults in Alabama's Expanded Black Belt. "

You are invited to participate in a research study to examine the levels of Trust in the Health Care System and Hope to Quality of Life Satisfaction. The study is being conducted by Debra Floyd Lett, Doctoral Candidate, under the direction of Dr. Ivan Watts, PhD in the Auburn University Department of Education Foundations Leadership and Technology. You were selected as a possible participant due to your affiliation with the Southeast District Missionary Baptist Churches. You may participate in this study if you are at least age 19 or older and can read and write English.

What will be involved if you participate? Your participation is strictly voluntary. If you decide to participate in this research study, you will be asked to complete the anonymous survey. Your total time commitment will be approximately 60 to 90 minutes.

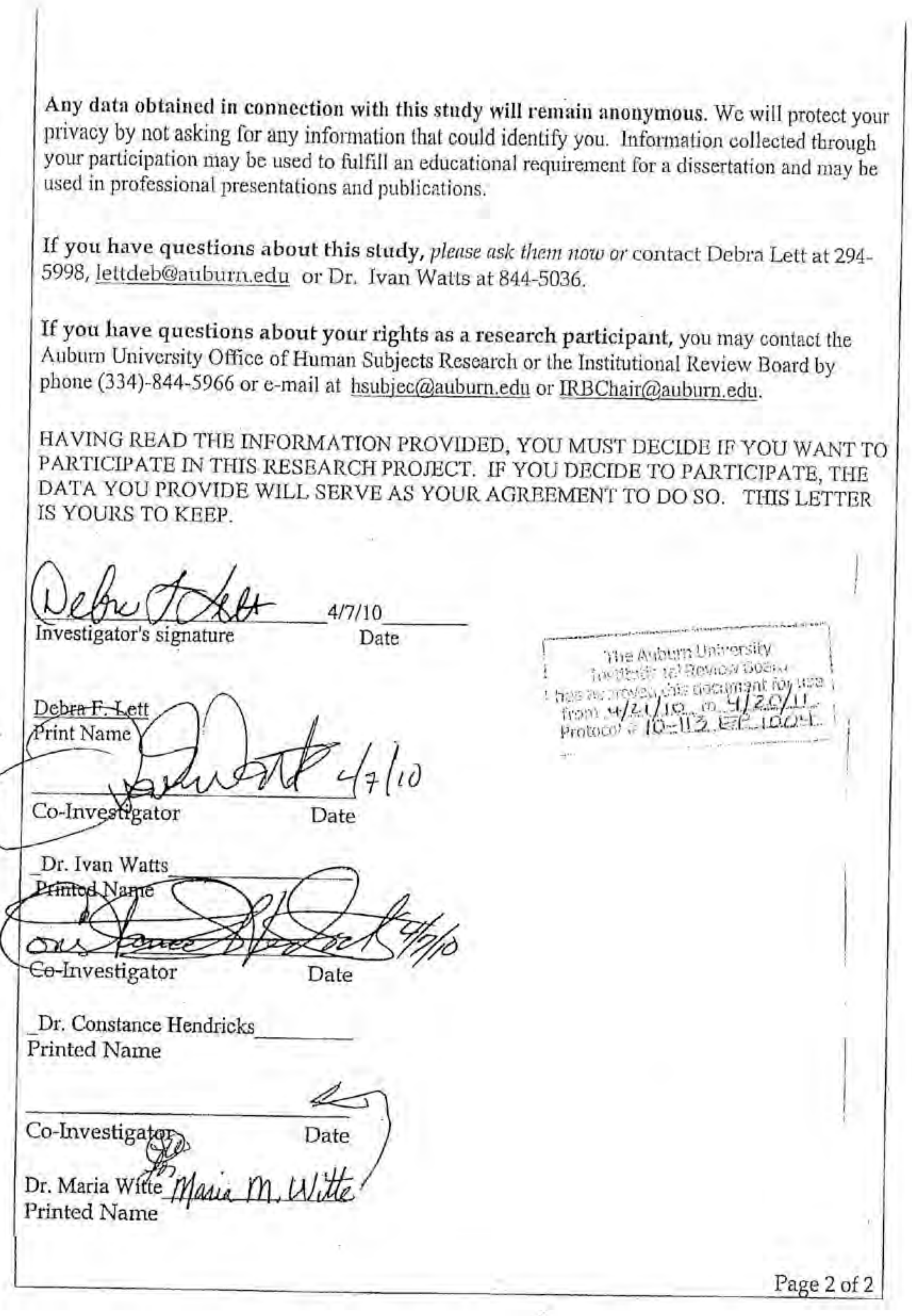
Are there any risks or discomforts? The risks associated with participating in this study are risk of privacy. To minimize these risks, you will not be asked for any information that could identify you and surveys will be destroyed once the study is completed.

Are there any benefits to yourself or others? If you participate in this study, you can expect to answer questions on your perception of trust in the health care system and hope to quality of life satisfaction. I cannot promise that you will receive any benefits. New models of development for health care in Alabama's Expanded Black Belt counties might possibly occur over a long term time period.

Will you receive compensation for participating? To thank you for your time you will be offered a $5.00 Gift Certificate, a Certificate of Completion and a bottle of water.

Are there any costs? If you decide to participate, there will be no cost to you.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of EFLT.



Any data obtained in connection with this study will remain anonymous. We will protect your privacy by not asking for any information that could identify you. Information collected through your participation may be used to fulfill an educational requirement for a dissertation and may be used in professional presentations and publications.

If you have questions about this study, *please ask them now or* contact Debra Lett at 294-5998, lettdeb@auburn.edu or Dr. Ivan Watts at 844-5036.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

Debra F. Lett 4/7/10
Investigator's signature Date

Debra F. Lett
Print Name

4/7/10
Co-Investigator Date

Dr. Ivan Watts
Printed Name

4/7/10
Co-Investigator Date

Dr. Constance Hendricks
Printed Name

Co-Investigator Date

Dr. Maria Witte Maria M. Witte
Printed Name

The Auburn University
Institutional Review Board
has approved this document for use
from 4/21/10 to 4/20/11
Protocol # 10-113 EP 1004

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APPENDIX B

SURVEYS: Demographics, MMI, H2HMS and Q-LES-Q

Directions: This study consists of four parts that tell me about you. Please answer each question and do not skip any of the items. Remember, there is no right or wrong answer. I will give you specific directions for each part before you begin.

Part One: Tell Me About You

SECTION A: DEMOGRAPHICS Circle the appropriate response.

1. Are you Male Female

2. Which of the following groups do you consider yourself belonging to? (Circle One)
   1 African-American
   2 White
   3 Asian
   4 Hispanic (white)
   5 Hispanic (non-white)
   6 Native Hawaiian or other Pacific-Islander
   7. American Indian or Alaskan Native
   8. Other

3. What is your age today? (OPTIONAL)
   1. 19-25 years 2. 26-35 years 3. 36-55 years 4. 56-69 years
   5. 70+

4. Are you currently uninsured?
   1 – Yes 2 – No

5. What type of insurance do you currently have?
   0. None
   1. Private health insurance, from your job or somebody else's job.(Blue Cross/Blue Shield)
   2. Medicare, a government plan that pays health care bills for people over age 65 and people who are disabled
   3. Medicaid, also called medical assistance
   4. CHAMPUS/CHAMPVA
   5. Other

GO to Next Page

1

6. Was there any time in the past two years when you were completely without any health plan or insurance coverage?
1 – Yes 2 – No

7. How would you describe your current employment status? (OPTIONAL)

1 Working outside the home full time
2 Working outside the home part time
3 Retired
4 Attending school
5 Maintaining the home
6 Unemployed
7 Disabled
8 Other – specify

8. What category best describes your job? (**Circle One**)
1. Helper/Laborers) plant production/assembly line, hotel maid, Nurse's aid, etc.)
2. Craft Persons; mechanics, installers, trade persons (seamstress, florist, artist, etc.)
3. Service Occupations (hair dresser, food/service occupations, bus drivers, etc.)
4. Technical/Sales/Administrative Support (secretaries, bank tellers, telephone operators, etc.)
5. Executive / Managerial (administrators, managers, assistant managers) Professional / Specialist (engineers, scientists, paralegal, nurse)

9. What is the highest level of education you completed? (**Check only one**)
1. Completed elementary school
2. Completed high school
3. Completed trade/vocational school or community college
4. Attended college
5. Completed college
6. Master's

10. Are you the first in your family to graduate from college?
1. Yes
2. No

11. Circle the Income range that matches your last year's earnings.
1 Less than $5,000
2 $5,000 - $9,999
3 $10,000 - $14,999
4 $15,000 - $34,999
5 $35,000 - $54,999
6 $55,000 - $65,999
7 $66,000 - $89,999
8 $90,000 or above

GO to Next Page

SECTION II: HEALTH STATUS

11. In general, how would you describe your own health? Would you say that it is excellent, very good, good, fair, or poor?

1	Excellent
2	Very Good
3	Good
4	Fair
5	Poor

12. When was the last time you visited a physician?

0. 1 week ago
1. 2 weeks ago
2. 3 weeks ago
3. 4 weeks ago
4. 2 months ago
5. 6 months ago
6. 1 year ago
7. Never

Have you been told by a doctor or other healthcare professional that you have any of the following health problems?

Item	Have been told	Have not been told
1. High blood pressure	1	2
2. Heart attack, or heart disease	1	2
3. Cancer	1	2
4. Diabetes or sugar diabetes	1	2
5. Anxiety or depression	1	2
6. Obesity	1	2
7. Asthma	1	2
8. Arthritis	1	2
9. Any other health problems	1	2

GO to Next Page

Part II

Directions: Read each statement and then indicate your own personal feelings about the statement by circling the number that best describes you. Please describe as you really are, not as you would like to be. Please use the following key.

1. means that you strongly disagree with the statement
2. means that you disagree with the statement
3. means that you agree with the statement
4. means that you strongly agree with the statement

Item	Strongly Disagree	Disagree	Agree	Strongly Agree
1. You'd better be cautious when dealing with healthcare organizations.	1	2	3	4
2. Patients have sometimes been deceived or mislead by healthcare organizations.	1	2	3	4
3. When healthcare organizations make mistakes they usually cover it up.	1	2	3	4
4. Healthcare organizations have sometimes done harmful experiments on patients without their knowledge.	1	2	3	4
5. Healthcare organizations don't always keep your information totally private.	1	2	3	4
6. Sometimes I wonder if healthcare organizations really know what they are doing.	1	2	3	4
7. Mistakes are common in healthcare organizations.	1	2	3	4

GO to Next Page

Part III

Directions: Read each statement and then indicate your own personal feelings about the statement by circling the number that best describes you. Please describe as you really are, not as you would like to be. Please use the following key.

4. means that you strongly agree with the statement
3. means that you agree with the statement
2. means that you disagree with the statement
1. means that you strongly disagree with the statement

How strongly do you agree/disagree that:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I am positive about most aspects of my life.	4	3	2	1
2. I look forward to an enjoyable future.	4	3	2	1
3. I do not have good luck in my life.	4	3	2	1
4. There are things I want to do in life.	4	3	2	1
5. I am able to set goals I want to achieve.	4	3	2	1
6. I am at peace with myself.	4	3	2	1
7. My life has meaning.	4	3	2	1
8. I make plans for my own future	4	3	2	1
9. I am so overwhelmed, nothing I do will help.	4	3	2	1
10. I intend to make the most of my life.	4	3	2	1
11. I am positive about the future.	4	3	2	1
12. I feel trapped, pinned down.	4	3	2	1
13. I feel uninvolved with life.	4	3	2	1
14. I spend time planning for the future.	4	3	2	1
15. I am able to accomplish my goals in life.	4	3	2	1
16. I am valued for what I am.	4	3	2	1
17. I am hopeless about some parts of my life.	4	3	2	1
18.It is hard for me to keep up my interest in previously enjoyable activities	4	3	2	1
19. It seems as though all my support has been withdrawn.	4	3	2	1
20. I will not have good luck in life.	4	3	2	1
21. I feel loved.	4	3	2	1
22. I am preoccupied with troubles that prevent my planning for the future.	4	3	2	1

GO to Next Page

Part IV

This questionnaire is designed to help assess the degree of enjoyment and satisfaction experienced <u>during the past week.</u>

Directions: Read each statement and then indicate your own personal feelings about the statement by circling the number that best describes you. Please describe as you really are, not as you would like to be. Please use the following key.

1. means that you feel very poor with the statement
2. means that you feel poor with the statement
3. means that you feel fair with the statement
4. means that you feel good with the statement
5. means that you feel very good with the statement

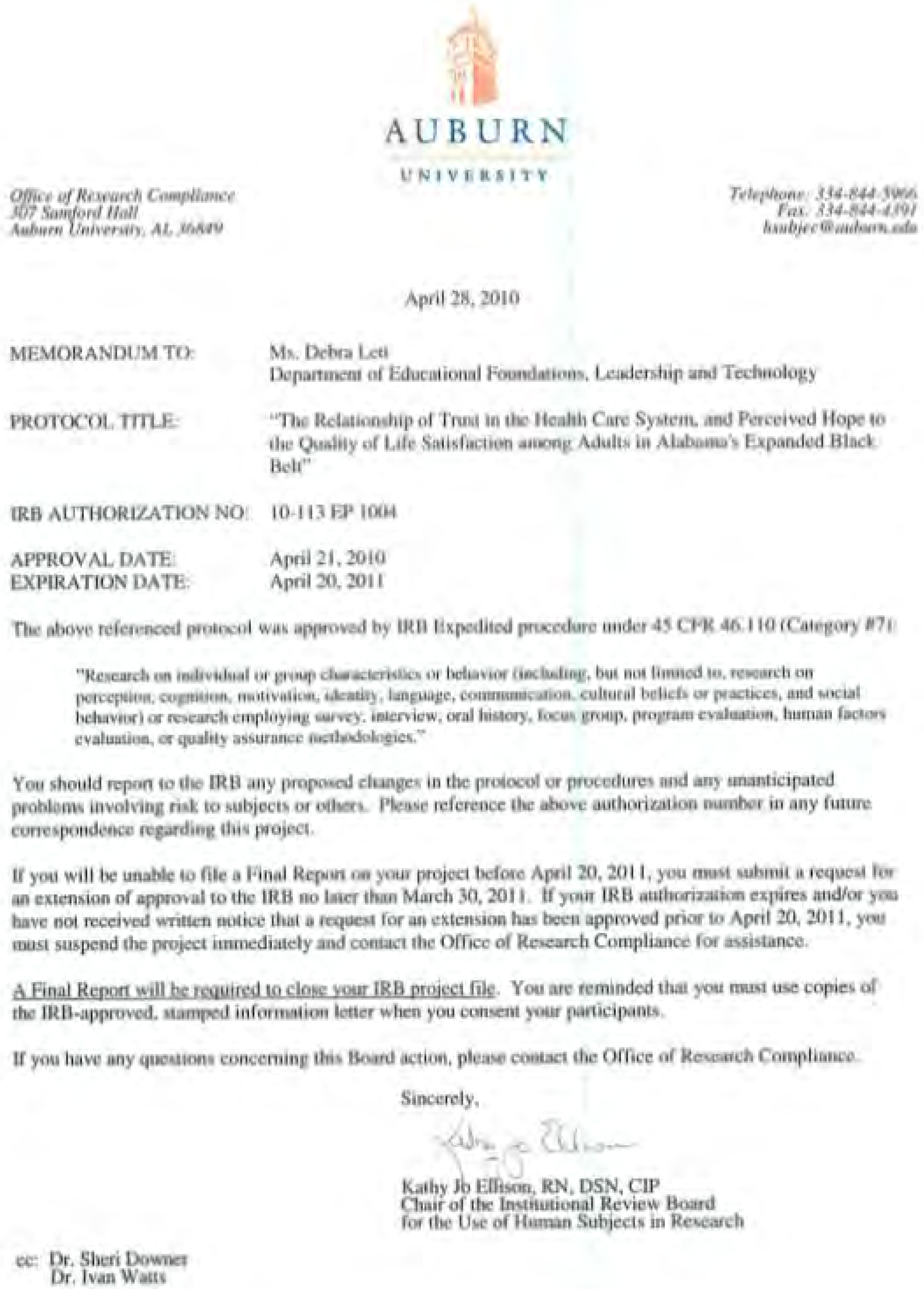
General Activities **Overall Level of Satisfaction**

Taking everything into consideration, during the past week how satisfied have you been with your	Very Poor	Poor	Fair	Good	Very Good
1. Physical health	1	2	3	4	5
2. Mood	1	2	3	4	5
3. Work	1	2	3	4	5
4. Household activities	1	2	3	4	5
5. Social Relationships	1	2	3	4	5
6. Family Relationships	1	2	3	4	5
7. Leisure time activities	1	2	3	4	5
8. Ability to function in daily life	1	2	3	4	5
9. Sexual Drive, interest and/or performance	1	2	3	4	5
10. Economic Status	1	2	3	4	5
11. Living/housing situation	1	2	3	4	5
12. Ability to get around physically without feeling dizzy of unsteady or falling	1	2	3	4	5
13. Your vision in terms of ability to do work or hobbies	1	2	3	4	5
14. Overall sense of well being	1	2	3	4	5
15. Medication If not taking any, check here and leave blank	1	2	3	4	5
16. How would you rate your **overall life satisfaction and contentment** during the past week	1	2	3	4	5

Thank You

APPENDIX C

INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL LETTER



AUBURN

UNIVERSITY

Office of Research Compliance
307 Samford Hall
Auburn University, AL 36849

Telephone: 334-844-5966
Fax: 334-844-4391
hsubjec@auburn.edu

April 28, 2010

MEMORANDUM TO: Ms. Debra Lett
Department of Educational Foundations, Leadership and Technology

PROTOCOL TITLE: "The Relationship of Trust in the Health Care System, and Perceived Hope to the Quality of Life Satisfaction among Adults in Alabama's Expanded Black Belt"

IRB AUTHORIZATION NO: 10-113 EP 1004

APPROVAL DATE: April 21, 2010
EXPIRATION DATE: April 20, 2011

The above referenced protocol was approved by IRB Expedited procedure under 45 CFR 46.110 (Category #7)

> "Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies."

You should report to the IRB any proposed changes in the protocol or procedures and any unanticipated problems involving risk to subjects or others. Please reference the above authorization number in any future correspondence regarding this project.

If you will be unable to file a Final Report on your project before April 20, 2011, you must submit a request for an extension of approval to the IRB no later than March 30, 2011. If your IRB authorization expires and/or you have not received written notice that a request for an extension has been approved prior to April 20, 2011, you must suspend the project immediately and contact the Office of Research Compliance for assistance.

A Final Report will be required to close your IRB project file. You are reminded that you must use copies of the IRB-approved, stamped information letter when you consent your participants.

If you have any questions concerning this Board action, please contact the Office of Research Compliance.

Sincerely,

Kathy Jo Ellison

Kathy Jo Ellison, RN, DSN, CIP
Chair of the Institutional Review Board
for the Use of Human Subjects in Research

cc: Dr. Sheri Downer
Dr. Ivan Watts

APPENDIX D

LaVeist Consent and Request for Use of MMI

From: "LaVeist, Thomas" <tlaveist@jhsph.edu> Wednesday - March 31, 2010 6:59 AM
To: "'lettdeb@auburn.edu'" <lettdeb@auburn.edu>
Subject: Re: Permission to Use the Measuring Trust in Health Care:Medical Mistrust Index Version 2.1
Attachments: Mime.822 (4690 bytes) [Save As]

Thank you for contacting me. I published the MMI including the complete wording of the questions so that it would be public domain. Therefore you do not need permission to use it. All you need to do it properly cite it as a source in your dissertation. Make sure you use the version published in "Health Services Research" and not the older version which was published in "Medical Care Research and Review." Best of luck with your research. Please let me know your results. Best regards, TL

Sent from my T-Mobile Blackberry.

----- Original Message -----
From: Debra Lett <lettdeb@auburn.edu>
To: LaVeist, Thomas
Sent: Wed Mar 31 02:53:06 2010
Subject: Permission to Use the Measuring Trust in Health Care: Medical Mistrust Index Version 2.1

** High Priority **

Hello Dr. LaVeist:

My name is Debra Lett, I am a Doctoral candidate at Auburn University in the College of Education in Auburn, Alabama. I am preparing to begin the dissertation process. One of the variables I will be exploring centers on trust in the healthcare system. Please give me permission to use your Measuring Trust in Health Care:Medical Mistrust Index Version 2.1 and share with me how to analyze collected data.

Thank you, Dr. LaVeist for your consideration of the use of the Measuring Trust in the Health Care:Medical Mistrust Index Version 2.1. In reviewing the literature, I found that this tool is highly valid and reliable. Use of the Mistrust Index would greatly enhance the credibility and scholarship of my study. I was elated when I found the Mistrust Index which you developed. Fleshing out the literature in the area of Health Disparities is challenging in many ways, yet so dishearteningly. I so admire, applaud and appreciate all of the work that you have in this area. If required, I can also be reached by phone at 334-279-6186 or 334-294-5998 if you require questions.

Respectfully,

Debra Lett

APPENDIX E

CONSENT TO USE HENDRICKS H2HMS

Making a Health Promotion Connection Outreach Program
Constance S. Hendricks, PhD, RN, FAAN, Principal Investigator
Professor/Auburn University School of Nursing
1850 Delia Drive, Auburn, AL 36830
334-332-3850; 334-844-6749
cshzhope@bellsouth.net

This program was originally funded by a Mentored Research Scientist Development Award for Minority Investigators by the National Institute of Nursing Research/ National Institutes of Health (K01 NR00128-01)

March 30, 2010

Ms. Debra Lett
7505 Copperfield Drive
Montgomery, AL 36117

Dear Ms. Lett:

Thank you for your interest in the **Hendricks/Murdaugh/Hendricks Hope Scale** (**H2M Hope Scale)©**. The **H2MHS** was designed to measure perceived levels of hope (positive and negative). The H2HMS is a 22-item scale that uses a four-point Likert format to measure response frequencies("disagree a lot" = 1, "disagree a little" = 2, "agree a little" = 3, "agree a lot" = 4). The possible range of scores is 22 to 88, or 1 to 4 if using the mean of the values assigned based on the four point scale. There are two subscales: Hopefulness (positive hope) and Hopelessness (negative Hope). For the Hopefulness subscale (positive hope), higher scores indicate higher perceived levels of hope (n=13 items). For the Hopelessness subscale (negative hope), higher scores indicate higher perceived levels of negative hope. (n=9 items) In either subscale, a mean score between 4 and 3 is considered high, between 3 and 2 is considered moderate, and mean score between 2 and 1 is considered low The reliability for the total hope instrument is 0.94 as measured by Cronbach's alpha; 0.90 for positive hope subscale and 0.94 for the negative hope subscale. The reading level for this tool is grade 4.9. The instrument has been used with HIV+ adult women in rural South Carolina and adult caregivers in Virginia. Manuscripts describing the reliability and validity of the **H2MHS** have been published in the following:

Hendricks, C.S., Hendricks, D., Murdaugh, C., Tavakoli, A., Gibbons, M.E., Servonsky, E.J., Brock, T., Burton, P.D., Gilmore, K.J. (2005). Psychometric testing of the Miller Hope Scale with rural Southern adolescents. *The Journal of Multicultural Nursing and Health, 11(3)*, 41-50;

Hendricks, D.L., Hendricks, C.S. (2005). The relationship of hope and self-efficacy to health promoting behaviors among student-athletes attending historically Black colleges and universities. *The Journal of Multicultural Nursing and Health, 11(3),* 23-34

Hendricks, C.S., Hoffman, H., Robertson-Laxton, Tavakoli, A. Mathis, D., Hackett, D., Byrd, L. (2000). Hope as a predictor of health promoting behavior among rural southern early adolescents. *Journal of Multicultural Nursing and Health*. *6* (3), 5-11.

Hendricks, C.S. (1998). Perceptual determinants of early adolescent health promoting behaviors: Model development. *Journal of Theory Construction & Testing, 2* (1), 13-22.

Copyright of all versions of the AHS© is held by Constance S. Hendricks, PhD, RN, Carolyn L. Murdaugh, PhD, RN, FAAN and Denisha L. Hendricks, EdD. You have permission to use the H2MHS© in your studies for non-commercial data collection purposes provided that the content is not altered in any way and that the copyright/permission statement at the end is retained. You may have copies made from the copy provided. **Content of the H2MHS should not be altered in any way and should show the following copyright permission statement.**

Copyright of all versions of the H2MHS© is held by Hendricks, C., Murdaugh, C. & Hendricks, D. (2004). Reproduction without consent is not permitted. Permission to use this scale must be obtained from the: Making A Health Promotion Connection Program, 300 North Dean Road Suite 5-118, Auburn, AL 36830

Permission to use this scale for any other use must be obtained from the: Making A Health Promotion Connection Program. Best wishes in your research endeavors. Please provide us with a copy of your results, as it will assist us in assessing the efficacy of the instrument. If you have additional questions, please contact me.

Sincerely,

Constance Smith Hendricks

Constance Smith Hendricks, PhD, RN, FAAN
Professor
W. K. Kellogg Project LEAD Fellow
NINR/NIH Minority Mentored Research Scientist

ATTACHMENTS

APPENDIX F

REQUEST AND CONSENT TO USE Q-LES-Q

From:	"Jean Endicott, Ph.D." <je10@columbia.edu>	Monday - March 29, 2010 10:21 AM
To:	Debra Lett <lettdeb@auburn.edu>	
Subject:	Re: Permission to Use Abbreviated Quality of Life Enjoyment and SatisfactionQuestionnaire (Q-LES-Q-18)	
Attachments:	PSY5559.pdf (229732 bytes)	[Open] [Save As]
	QLESQPub10-13-l09.doc (89600 bytes)	[Open] [Save As]
	QLESQscore.doc (43520 bytes)	[Open] [Save As]
	RegQLESQ.doc (44032 bytes)	[Open] [Save As]
	SFQLESQ.doc (23552 bytes)	[Open] [Save As]
	Mime.822 (595027 bytes)	[Save As]

Dear Ms Lett,

I am attaching the following Q-LES-Q materials....a copy of the Full (ie longer) version, a copy of the Short Form (same content as the General Activities section of the Full version), scoring instructions for both, a list of publications of which we are aware, a paper based upon a sample of subjects who were not in treatment.

You have my permission to use the Q-LES-Q (either version) in your dissertation study.

Do not hesitate to contact me if you have questions.

Regards,
Jean Endicott, Ph.D.

Debra Lett wrote:
> ** High Priority **
>
> Hello Dr. Endicott:
>
> My name is Debra Lett, I am a Doctoral candidate at Auburn University in the College of Education in Auburn, Alabama. I am preparing to begin the dissertation process. One of the variables I will be exploring centers on quality of life. Please give me permission to use your Abbreviated/Short Form of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-18) and share with me how to analyze collected data.
>
> Thank you, Dr. Endicott for your consideration of the use of the Quality of Life Enjoyment and Satisfaction Questionnaire. In reviewing the literature I found that this tool is highly valid, reliable and stable. Use of the Questionnaire would greatly enhance the credibility and scholarship of my study. I can also be reached by phone at 334-279-6186 or 334-294-5998 if you require questions.
>
> Respectfully,
> Debra Lett

--

Jean Endicott, Ph.D.
Unit 123
1051 Riverside Drive, N.Y. 10032

Phone: (212) 543-5536
Fax: (212) 543-5386

APPENDIX G

CONSENT TO SURVEY MEMBERS OF THE SOUTHEAST STATE CONVENTION AND REQUEST LETTERS

From: clarence noble <cpn1945@bellsouth.net> Saturday - April 3, 2010 10:51 PM
To: Debra Lett <lettdeb@auburn.edu>
Subject: Re: Letter of Permission to Survey Churches in Southeast District

Attachments: Mime.822 (6852 bytes) [Save As]

Ms. Lett,

You have my permission and support to survey the churches of the Southeast District State Convention to aid you in gathering data for research. I hope that the information will add much to efforts to complete you dissertation. You might want to consider conducting your survey during our Annual Session, May 10 - 13, 2010, Enterprise Civic Center, Enterprise, AL. Wish you well with this endeavor.

Clarence P. Noble

April 2, 2010

Debra Lett
Auburn University College of Education
Auburn, AL

Dr. C.P. Noble
President of Southwest State Convention
Tuskegee, Al

Dear Dr Noble:

I am a doctoral candidate at Auburn University in the College of Education, Educational Foundations Leadership and Technology Department in the area of Higher Education Administration. I am in the initial stages of planning for my dissertation study. I want to identify how people feel about the healthcare system measuring their level of care and their personal hope and its impact on their quality of life. The focus of this study is the on the relationship of trust in the health care system and hope to Quality of life satisfaction among adults in Alabama's expanded Black belt. I anticipate with your permission to survey adults from Alabama's Extended Blackbelt during a time designated early spring through summer. Your permission to allow me to survey parishioners from the Southeast District would greatly enhance the quality of this study. The study results will be shared with you per your request.

Thank you Dr. Noble for considering to allow me to survey adults from the Southeast District, and analyzing their level of hope and trust in the health care. Findings from this study will influence future research.

Respectfully,
Debra F. Lett, EdD (Candidate), MSN, MPA, RN

--- On **Fri, 4/2/10, Debra Lett <*lettdeb@auburn.edu*>** wrote:

From: Debra Lett <lettdeb@auburn.edu>
Subject: Letter of Permission to Survey Churches in Southeast District
To: cpn1945@bellsouth.net
Date: Friday, April 2, 2010, 6:11 PM

** High Priority **

Hello Dr. Noble:

As stipulated, a letter is attached requesting your permission to survey parishioners of the Southeast District. Thank you so much for considering to allow members to participate in this survey if desired. I would be delighted to share with you the results of the study if requested once completed.

Much success to you in all of your efforts of innovation in the Southeast District.

Respectfully,
Debra Lett

APPENDIX H

INCLUSION/EXCLUSION CRITERIA

Relationship of Trust in the Health Care System and Perceived Hope to the Quality of Life Satisfaction Among Adults in Alabama's Expanded Black Belt

Are you age 19 years of age or older and can read and write English?

Do you attend one of the Missionary Baptist Churches in Alabama's Extended Black Belt?

Do you want to share your feelings about assessing healthcare systems in your area and how you feel about life every day?

If you answered ***YES*** to these questions, you may be eligible to participate in an important study concerning feelings about the health care system in your area.

The purpose of this research study is to determine the essence of hope and trust and their impact to a life of quality and the significance relative to the health care system. Your participation will require you to complete a survey and the time commitment will be 60 to 90 minutes. For participating in the study you will receive a gift card, a certificate, and a bottle of water.

Please contact Debra Lett, RN, MSN at lettdeb@auburn.edu or **(334) 294-5998** for more information.

APPENDIX I

RESEARCHER VERBAL ANNOUNCEMENT

Verbal Statement

I am a doctoral candidate at Auburn University in the College of Education, Educational Foundations Leadership and Technology Department in the area of Higher Education Administration. My doctoral research focuses on identifying how people feel about the healthcare system measuring their level of trust, their personal hope and its impact on quality of life. The focus of this study is the on the relationship of trust in the health care system and perceived hope to the quality of life satisfaction among adults in Alabama's expanded Black Belt. I am needing your assistance to complete a survey about the health care delivery system and yourself. If you choose to participate, I would need you to complete a brief survey. It will take approximately 60 minutes to complete. I will be at the designated area at the conclusion of this meeting to distribute the survey to those willing to complete it and participate.

APPENDIX J

GIFT CARD

TO: FROM: $

For balance inquiry, call 1-888-537-5503 or go to walmart.com/giftcards or samsclub.com

SCRATCH OFF GENTLY WITH COIN

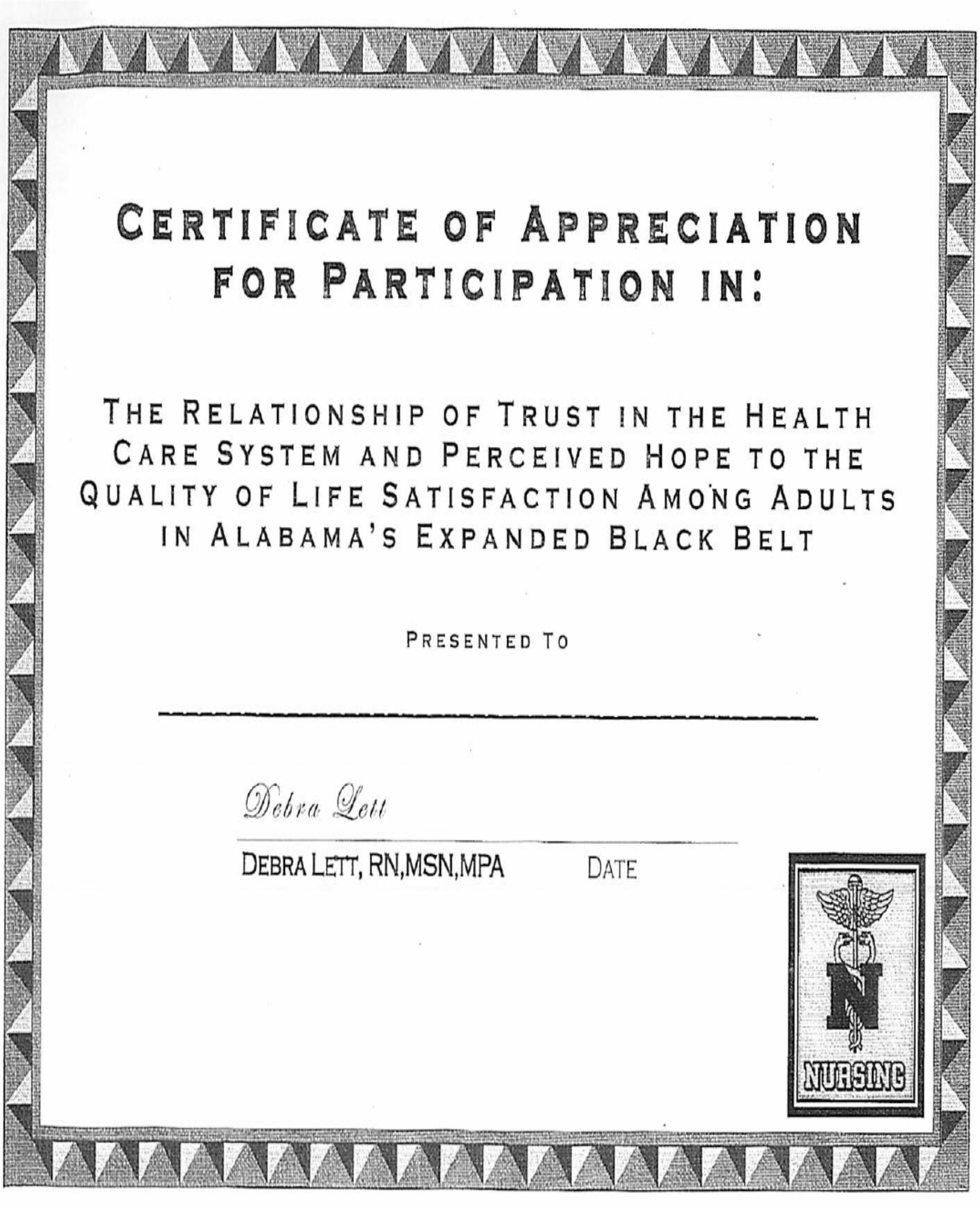
SC87458601796320785

VL-10670

605864577642

APPENDIX K

CERTIFICATE OF COMPLETION



CERTIFICATE OF APPRECIATION FOR PARTICIPATION IN:

THE RELATIONSHIP OF TRUST IN THE HEALTH CARE SYSTEM AND PERCEIVED HOPE TO THE QUALITY OF LIFE SATISFACTION AMONG ADULTS IN ALABAMA'S EXPANDED BLACK BELT

PRESENTED TO

____

Debra Lett

DEBRA LETT, RN,MSN,MPA DATE