# SELF-PERCEIVED CREDIBILITY OF BLACK WOMEN IN HEALTHCARE ADMINISTRATION

by

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ABSTRACT

The focus of this qualitative descriptive case study was on the lived experiences of Black female midlevel health care leaders, who may or may not aspire to health care senior leadership positions. Ascertaining how trustworthiness connected to self-assessment, transformational leadership and advancement opportunities provides valuable information to help Black females attain senior-level leadership in health care administration and understand reasons why there may be a lack of opportunity. This study assessed the understanding of a Black woman's trustworthiness (credibility) using a self-assessment measured by the four behavioral dimensions of competence, integrity, goodwill, and transparency. The study also examines how self-perception of credibility impacts their confidence, creativity, performance, and most importantly their opportunities for leadership advancement. This study identified how Black women view themselves based on the four dimensions of trustworthiness, by having participants complete a written self-assessment and by response to questions in an oral interview. The knowledge gained from this study will better prepare Black females for identification of self-imposed hindrances for leadership advancement as well as how the imposition of restrictions from others based on race transfer to become self-imposed hindrances. This study is of relevance as it provides women with information of the self-perception of trustworthiness as a leadership competency, helps Black women in health care administration gain valuable insight for career advancement, which in turn helps address the lack of diversity at the senior leadership level.

DEDICATION

I dedicate this work to the memory of Dr. Delorese Ambrose, founder of Ambrose Consulting & Training. Dr. Ambrose earned a Doctor of Education degree from Columbia University in 1979 and was adjunct Professor of Management at Carnegie Mellon University for eighteen years. She also served as a faculty member of the Institute of Management Studies (IMS) where she lectured throughout the U.S. and in Canada, Amsterdam, Brussels, London, Manchester, and Scotland. Dr. Ambrose provided coaching programs for clients such as Alcoa, KPMG, Brigham and Women's Hospital, and the U.S. Treasury Department. She authored three books: Leadership: The Journey Inward, Healing the Downsized Organization and, Making Peace with Your Work: An Invitation to Find Meaning in the Madness.

Dr. Ambrose was on the cutting edge of identifying and addressing emerging workplace diversity issues offering personal mastery and organizational effectiveness to companies around the globe just prior to her death. Dr. Ambrose was my mentor and friend. Her death had a significant impact on me, which caused a substantial delay in the completion of this study. Dr. Ambrose worked closely with me in the early thought development of this dissertation focusing on self-perception of trustworthiness. Prior to her death in 2009, Dr. Ambrose gracious provided her written approval for use of her Interpersonal Trust Profile (ITP) tool for this research (see Appendices B and C). She would be proud to see this completed work that has her handprint throughout.

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I give honor to God for the completion of this very long journey. God has strengthened me to preserver even with many starts and stops. I am so grateful!

This work would not have been possible without the support of the faculty of the University of Phoenix, School of Advance Studies. The input and guidance over the years has been invaluable.

I am grateful for the ongoing support of my family. All that I do is for my son, Jonathan, whom I love dearly. His regular check-ins with his Ma about this dissertation, proved invaluable during the homestretch. I would like to thank my mother, Ruby, for her love and support. My Mother is always a cheerleader for all her children and grandchildren with all that we do. Her encouragement is irreplaceable. I would like to thank my sisters, Jacqueline, Victoria and Pamela for always being there for me. Who needs best friends when you have the best sisters? I also acknowledge my father, Clyde and my sister Janet. I know they are both smiling down on me from Heaven. My Father is likely saying at this moment, "Alright Yellowduck, way to go youngin!"

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# Chapter 1

## Introduction

There is a lack of Black female leaders at the decision-making level in health care organizations (Gathers, 2003; Silver, 2013; Thew, 2019; Wolliston, 2008). In a published benchmark study of United States hospitals in 2012, minorities make up less than 15% of board members and executive leadership positions ("Diversity and Disparities," 2012). Some suggest that affording leadership opportunities to women of color would be a benefit to any company (Pace, 2018). Black women in senior-level leadership in health care could directly impact the patient care provided to the many people of color receiving services at those same organizations. As contributing voices at the decision-making table, advocating on behalf of underserved minorities, the Black female perspective may prove invaluable. This unofficial role would be above and beyond what the individual may be trained or educated to do as a leader. It has become more accepting in health care that diversity in leadership adds value to achievement of service excellence (Herrin et al., 2018; Silver, 2013). Implementing actionable diversity and inclusion models to validate the acceptance of this value add to leadership would be the important next step in opportunity for Black female leaders.

In U.S. health care organizations, the patient population reflects the diverse racial and ethnic make-up of the nation ("Diversity and Disparities," 2012; Rich, 2013; Sullivan Commission on Diversity in the Healthcare Workforce [Sullivan], 2004), particularly within the Black community where health concerns are greater than other populations (Pace, 2018). According to the U.S. Department of Health and Human Services (2017) Office of Minority Health, the death rate for African Americans is generally higher than Whites for ailments including heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS.

Administrative decision-makers do not reflect the same diversity in backgrounds and perspectives to support this identified disparity ("Diversity and Disparities," 2012; Gathers, 2003; Rich, 2013; Sullivan, 2004). Hospitals reflective of diversity at the senior leadership and board levels show greater commitment to diversity initiatives and achievement of clinical excellence (Herrin et al., 2018). Even with such clarity, the presence of Black people in executive health care is minimal (Silver, 2013).

Decision-makers behind the scenes of health care organizations do not reflect the diversity in backgrounds and perspectives needed for successful health care outcomes for all ethnicities and cultures represented (Gathers, 2003; Herrin et al., 2018; Pace, 2018). Given the identified decline in minority enrollment in medical schools, this imbalance may continue (Bland, 2019; Ramirez, 2012; Sullivan, 2004). The lack of promotional opportunities, acknowledgment of talent, and self-perceived credibility may be contributing factors to consider. There is a need to identify alternative ways for creating opportunities for experienced Black professionals trained as health care administrators to advance in leadership (Bland, 2019). The lack of focus on diversity and inclusion continues to promote the silence of Black professionals on this concerning topic of leadership imbalance (Livingston, 2018).

The limited presence of Black women in health care may have different drivers including higher education barriers as seen prominently in nursing educational environments (Bland, 2019). The absence of Black female professionals in senior leadership positions in health care may be the result of both imposed factors and personal factors. Imposed factors might be organizational politics, racial and gender discrimination, while personal considerations might be a lack of experience or the self-perceived lack of trustworthiness (credibility). Leadership advancement requires individuals to be confident in their knowledge, skills, and abilities. For

Black women to leverage promotional opportunities, there may be a requirement for self-assessment to determine capability and leadership competence. Self-perception may prove beneficial by demonstrating an unidentified hindrance that has limited Black women from obtaining advancement opportunities (Bland, 2019).

The focus of this researcher was to present a qualitative descriptive case study offering identifiable leadership behaviors in the categories of competence, integrity, goodwill and transparency. Study participants were given opportunity to provide input to better understand if self-imposed restrictions create psychological or behavioral barriers to leadership advancement opportunities in health care administration. This descriptive case study presents an analysis of participants' self-assessment of their leadership skills using a questionnaire and interview questions.

This study incorporated the perspective of Black female midlevel leaders in health care, a population with limited consideration in previous leadership studies as discovered in a broad literature search seeking studies related to people of color in health care leadership. This descriptive case study was used to discover fundamental phenomena about leadership ability and self-imposed barriers to advancement in health care administration for Black females by means of analysis of the questionnaire and interview responses.

Chapter 1 contains the background, problem statement and reflects the purpose of this research study. The intent was to identify if there are self-imposed barriers to leadership advancement for Black women in the area of trustworthiness and the data was assessed for recommendations for overcoming such obstacles. This qualitative descriptive case study combined a narrative analysis of semistructured interviews with a content analysis of questionnaire responses. The findings of this study show self-perception of credibility

contributes to the lack of opportunity for leadership advancement for Black women in health care administration with a clear connection to limiting factors put upon them by others.

## Background

Black females and other minority groups do not have equal representation in higher levels of health care leadership (Bland, 2019; "Closing the Gap," 2015; "Diversity and Disparities," 2012; Silver, 2013). The administrative leadership in health care organizations deliberate daily over many serious issues related to health care disparities impacting Black people (Silver, 2013; Sullivan, 2004). According to the 2018 National Healthcare Quality and Disparities Report, Blacks, along with other minority groups, experience inferior quality of care greater than Whites by 40% across quality measures. The lack of diversity in health care leadership may be a contributing factor to such glaring health care disparities among African Americans (Herrin et al., 2018; Silver, 2013; Sullivan, 2004). Successful health care outcomes rely on an understanding of the population being served (Sullivan, 2004). Having diversity represented in key decision-making roles may significantly impact health care as there may be an increased sensitivity to culturally competent care that currently may not exist (Rosenberg, 2008; Sullivan, 2004).

The undertaking of workers in health care organizations is to meet the needs of their patients. To effectively do so, administrative leadership should be sensitive to the various needs of a diverse patient population (Herrin et al., 2018; Rosenberg, 2008; Watson & Rosser, 2007). To draw out this needed sensitivity, a leadership team should mirror the patient population. When leadership is not reflective of a diverse group, there is a negative impact as the organization's executive leaders are not benefiting from the wisdom of different perspectives at the decision-making level of the organization (Gauss, 2012; Silver, 2013; Wolliston, 2008).

Adding senior leaders who are culturally diverse and reflect the patient population is critical in resolving health care issues within the Black community ("Diversity and Disparities," 2012; Grant, 2010; Sullivan, 2004). Unfortunately, there continues to be inequality in health care leadership ("Diversity and Disparities," 2012; Grant, 2010; Rich, 2013; Silver, 2013), specifically for Black women (Pace, 2018). There have been studies to identify gaps based on inequality in health care education ("Closing the Gap," 2015, "Diversity and Disparities," 2012; Rosenberg, 2008; Silver, 2013; Sullivan, 2004); however, there appeared to be none focused on the possible self-imposed hindrances to advancement opportunities for Black women in health care. This researcher identifies possible self-imposed impediments of the African American midlevel health care leader.

Credibility interchangeable as trustworthiness is the cornerstone of leadership and the underpinning of this current study (Ambrose, 2009). Trustworthiness is linked to the leader's ability to influence others to achieve a desired future. It also determines to a large extent who gets selected to serve in leadership positions. Are Black women excluded from senior leadership positions because they lack confidence in key areas associated with trustworthiness? Credibility may be ascribed by others but may also be established by an individual based on their self-perception. How minority leaders view themselves as measured by four dimensions of trust provided the foundation for this current qualitative study. The four dimensions of trustworthiness used for this study are competence, integrity, goodwill and transparency.

**Equality in Healthcare Senior Management**

The problem reviewed in this qualitative descriptive case study is the lack of diversity in health care administrative leadership, specifically the limited representation of Black female professionals. Equality in health care senior management opportunities has yet to be obtained by

minorities in the United States ("Diversity and Disparities," 2012; Herrin et al., 2018; Jones, 1986; Ramirez, 2012; Silver, 2013; Sullivan, 2004). Within health care organizations, there have been goals established to encourage minorities to pursue health care careers; however, the results are not favorable (Clapp, 2010; Gathers, 2003; Grant, 2010; Hellinghausen, 2000; Ramirez, 2012; Rich, 2013). Diversity may be present in health care organizations in service and entry-level roles; however, inclusion still lacks when examining midlevel to senior-level leadership (Clapp, 2010, "Diversity and Disparities," 2012; Rich, 2013; Sullivan, 2004). Regarding experiences of African Americans and their ability to attain next-level leadership, Mathis and Jackson (2000) posit that in comparison to the Caucasian majority, minorities continue to face difficulty achieving leadership status in organizations (Rich, 2013; Selvam, 2013; Sullivan 2004).

Historically in the United States, Black women have not been afforded the same opportunities as their White male and female counterparts (Grant, 2010; Jackson, 2004; Sullivan, 2004; Thew, 2019). White male dominance in health care leadership still exists, while the service staff and recipients of the services reflect greater diversity (Pace, 2018). The dominant coalition is the group that has the most power reflecting control of the decision-making process (Jones, 2004). In health care organizations, dominant alliances may vary; however, in most cases, two dominant coalitions present, the patients receiving services and executive leadership of the organization, the President and the Vice Presidents. The patients are why health care organizations exist. Decisions made by health care executive leadership should be to meet the needs of the patients receiving service. If such decisions focus on meeting the needs of the patients, there should be decision-makers who reflect the same demographics as the patients. To

most effectively hear the voice of those being served, having a reflection of those being served around the table might provide valuable insight.

Studies show that race has an impact on career progression and shows up throughout the workforce (Gathers, 2003; Silver, 2013). The U.S. Bureau of Labor and Statistics (2017) published data on workforce demographics in the United States that depicts senior management positions are disproportionately 78% Caucasian men, not much higher than reported in 2000 at 93% Caucasian males (Mathis & Jackson, 2000). With minimal movement in numbers since 2000, there are still fewer than 15% of minorities who make up board members and executive leadership positions across most industries ("Diversity & Disparities," 2012). The lack of diverse demographics in board membership and senior leadership is reflected directly within health care ("Diversity and Disparities," 2012; Sullivan, 2004). Limited studies have focused on how an individual's self-assessment may contribute to this historically genuine concern within leadership diversity. Murray (2003), however, suggests that self-efficacy, as defined by Bandura (1997), may be a contributing factor for career development. Self-efficacy refers to the confidence level of individuals as they take action to achieve specific outcomes (Bandura, 1997; Bland, 2019). Individuals in current leadership roles may attribute their personal success to such self-awareness and confidence. This researcher shows a link between leadership self-awareness of the four dimensions of credibility and advancement opportunities for Black women in health care leadership.

The results of this study establish a link between self-identified trustworthiness and the minimal presence of racial minorities in senior decision-making health care positions as well as how limitations put upon them by others transfers to self-limitations. The results of this study also demonstrate the lack of confidence of Black women who desire higher level leadership roles

in health care is the result of years of feeling less credible due to unfair treatment by others in the workplace. It is essential to acknowledge that African Americans tend to attribute the lack of advancement opportunities to inequality in the workplace (Rich, 2013; Sullivan, 2004; Watson & Rosser, 2007). African Americans, in general, perceive there is little support of upward mobility, and discrimination is prevalent (Gathers, 2003). For the African American subpopulation, Black women, who participated in this study, this perception remains a reality (Ashley, 2013; Bland, 2019; Pace, 2018).

Central to the study of the self-imposed barriers to health care administrative leadership for Black women is the use of the Interpersonal Trust Profile (ITP; see Appendix B). This tool was combined with semistructured interviews to gather data. The ITP, or ITP, is an instrument that measures trustworthiness (credibility) on four dimensions of behavior: competence, integrity, goodwill and transparency (Ambrose, 2009). The ITP instrument combined with semistructured interviews guided the data collection to support this writer's theory that limitations on Black women's advancement opportunities may be due to their lack of confidence in the four dimensions of leadership credibility. For Black women who participated in this study, the extrinsic limitations are clear, as seen in past studies. Intrinsic limitations appear to not have been explored as possible reasons for blocks to leadership advancement, however, this study shows this is a real factor. This study provided an opportunity for self-reflection by participants allowing for data gathered using the questionnaire and interviews to support this identified theory.

In the health care profession as well as other industries, women and minorities believe there is a lack of advancement opportunities available to them beyond midlevel manager positions (Bland, 2019; Larson, 2006; Mason, 2019). The results of the literature review for this

study supported the belief that the unfairness in available opportunities for advancement in leadership links to negative historical external influences of ethnic, racial and gender inequalities (Mason, 2019; Silver, 2013; Sullivan, 2004; Watson & Rosser, 2007). This writer intended to show that Black women may also limit themselves due to a self-perceived lack of trustworthiness (credibility) as measured by the four dimensions of trust. This perspective formed the basis of this qualitative descriptive case study.

## Statement of Problem

Black female midlevel managers face blockades that limit their opportunity for advancement to higher levels of administrative leadership in health care organizations(Bland, 2019). Despite tremendous advances women professionals have experienced over the years, Black women still find themselves facing tougher challenges. Gender and pay inequities still exist for women in the workplace, with limited opportunity at the senior leadership level. Organizations are being challenged to focus on changing this narrative (Bland, 2019; Charlton, 2019; Pace, 2018).

There are examples of women in leadership roles and valid discussion regarding female professionals rising to senior leader levels. Rothman (2019) outlines recommendations for company culture change to promote advancement of women. Being underrepresented and portrayed as aggressive when displaying traits often attributed to men such as, being assertive or decisive, continue to hinder women in the workplace (Rothman, 2019). In addition to this commonality for all women in the workplace, Black women are also still striving to just reach level three leadership, the two levels from the C-Suite, in their respective organizations. Black females in manager and supervisor roles face all the existing leadership challenges of managing people, decision making, responsibility for business results as well as the add on of further

negative subjugation, resulting in inaccurate labels and stereotypes such as, the angry Black woman (Ashley, 2014). Black women continue to get mixed messages from co-workers and bosses, while simultaneously facing the challenge that their professional development must surpass all others in the workplace. The opportunities for advancement appear to not be available to Black women as health care senior leadership continues to be White male dominated.

There remains a significant gap in diverse leadership in health care organizations which demonstrates a need for solutions to drive transformation of this disparity ("Closing Healthcare's," 2020; Clapp, 2010; "Diversity and Disparities," 2012; Gauss, 2012; Herrin et al., 2018; Rich, 2013; Rosenberg, 2008). In consideration of possible solutions, could some of the barriers that limit diversity in health care leadership be self-imposed? Do Black women believe the myth of being less than others, White men or White women? How individuals view themselves may be a contributing factor to such barriers in health care administration and this perspective was uncovered as a result of this study.

The problem identified for this qualitative descriptive case study is the lack of Black female senior leaders in health care administration. There is an average of 14% minorities in executive hospital leadership roles, while the patient population is nearly 30% minority ("Diversity and Disparities," 2012). There is a lack of knowledge of the possible self-imposed barriers for Black female managers in a health care setting limiting their opportunity for advancement. The self-perceived barriers that midlevel managers encounter may significantly affect their ability to ascend to higher levels of leadership (Rosenberg, 2008). To understand the specific self-imposed barriers for Black women in health care midlevel management, the researcher assessed their perspectives on the four credibility dimensions of competency, integrity, goodwill, and transparency (Ambrose, 2009). The understanding of such barriers

provides insightful information to help with leadership advancement opportunities in health care administration for Black women.

## Purpose

The purpose of this qualitative descriptive case study was to explore the self-perceptions of Black female midlevel managers in health care administration on trustworthiness using a survey instrument and open-ended interview questions. The questionnaire and interview gave an examination of the aspiring Black woman's self-assessment of their leadership credibility utilizing the four dimensions of trust. This researcher used the survey instrument and interview to show how the results impact their ability to attain higher levels of leadership. The four dimensions of credibility as defined by Ambrose (2009) are competence, integrity, goodwill and transparency. Black women who aspire to be higher-level health care administrative leaders may gain an understanding of how they view themselves and how this may impact their opportunity for advancement. This study provides insightful information that reveals areas for needed behavioral changes for Black women in the areas of competence, integrity, goodwill, and transparency. There are real obstacles faced by Black women who aspire to be senior leaders and this study shows how those obstacles transition into self-limitation. Identifying the self-imposed constraints provides insightful information to help individuals make meaningful change as well as contribute to the ongoing study of leadership.

As minority females continue to face challenges in breaking through the glass-ceiling that block them from senior leadership positions, there is a need to identify and understand all contributing factors (Hyun, 2005; Pace, 2018; Wolliston, 2008). This study focused specifically on Black females in health care leadership and the possible contributing factor of a lack of trustworthiness as self-identified. Hellinghausen (2000) indicated there has been an effort by

health care organizations to diversify at the leadership level, however, the numbers remain low for minorities in leadership ("Diversity and Disparities," 2012). The reasons for this inequality often link to a lack of opportunity and discrimination. This researcher shows a connection to self-perception of the identified dimensions of credibility aligned to inequality.

As this researcher sought to identify self-imposed barriers for Black women that limit opportunities for the attainment of senior decision-making positions in health care administration, the outcomes provide some recommendations for overcoming such obstacles that can contribute to the overall study of leadership behaviors. The participants in this study were a nonrandom group of 20 Black female health care administrative professionals in manager level roles and frontline staff with desires to move up in leadership. The individuals identified for this study were all be administrative professionals currently or in the past employed by health care organizations in Boston, Massachusetts, and its surrounding communities. This study used a nonrandom snowball method of sampling to collect the needed data. Data was collected using open-ended interview questions (see Appendix D) combined with use of the ITP (see Appendix B).

The findings from this study contribute to the body of work on leadership development and the needed behaviors to achieve executive leadership positions, particularly for Black women and other minorities in health care administration. This study differs from previous studies of African American leaders, specifically Black women, as it focused on the self-perceptions of credibility and not the perception of others. The information gathered contributes new insight to the imbalance that exists at the senior management level in health care organizations. Being inclusive and reflect of leadership diversity should not be viewed as an insurmountable obstacle to overcome and should not be limited to a thoughtless process of

blending groups to meet Affirmative Action goals as set by the United States government. Diversity should be embraced by all, even those who have historically been excluded by others, specifically Black women. Removing any barriers to advancement opportunities, including self-imposed barriers, will add long term value to any organization and to the study of leadership.

## Significance of the Study

There are several identified areas of importance for this study. The first area of relevance is gaining an understanding of and identifying solvable root causes for the lack of African American leaders at the senior decision-making level in health care organizations (Grant, 2010; Rosenberg, 2008; Sullivan, 2006). The diversity seen at the highest leadership level, as well as among the direct health care providers, should be reflective of the racially diverse community receiving services (Pieper, 2004; Wolliston, 2008). The reasons for the disparity in leadership may never be fully known; however, this study shows possible contributing factors based on self-assessment data gathered from Black female participants.

The second area of the significance of this study is identifying how self-assessment contributes to leadership development. External influences of discrimination have been identified and studied (Bland, 2019; Watson & Rosser, 2007), however, little study has been conducted on possible self-imposed factors that contribute to the nominal presence of Black people as senior leadership in the workplace. The findings of this study help identify essential leadership traits that Black women may not be confident about, but any senior leader must possess to be successful. The benefit of this study to individuals who aspire to be senior managers in health care administration is the validation of self-evaluation in professional development. Self-transformation is a contributing factor to the revolutionary change of organizations and communities (Ambrose, 2003).

Self-awareness is a crucial component to maximizing efforts when leading others. Knowing one's self and professional strengths can immediately increase leadership effectiveness. Self-assessment can also help build credibility and possibly increase one's visibility and preparation to move to next level leadership. The negativity associated with Black women based on inaccurate descriptors is unfortunate for a potential population of aspiring leaders who meet and often exceed leadership requirements. For example, assertiveness is not aggressive, and Black women who are influential leaders should not be viewed as aggressive when they assert themselves. Another result of this research study is to help Black women in health care to focus less on that which simply is not accurate descriptors about them and focus more on factors they may need to develop that may avail them the opportunity for the leadership level they deserve.

In addition to individual benefits to aspiring Black female leaders, there are also benefits to health care organizations. Leaders of health care organizations can use the aggregate results of this study to establish learning programs, establish support groups, and offer coaching and mentoring for Black women and other minority groups as part of succession planning. This information helps prepare Black women and other employees of color for leadership roles and equip them with the needed capabilities to effectively drive organizational change efforts with success and ease.

Another area of significance is the possible implementation of diversity and inclusion programs that focus on mentoring and competency development for Black women and other diverse groups (Wolliston, 2008). Diversity efforts can launch in many organizations with limited focus on leadership and succession planning (Clapp, 2010; Grant, 2010). Core leadership competencies should include understanding the need for creating a culture committed to

diversity, equity, and inclusive. Cultural background, gender, gender identity, and all other categories reflecting differences all bring uniqueness to workplace diversity. Such diversity brings added value to any organization and leadership structure. As society moves from a closed-minded thought process to a more open mindset, there appears to be a slight rise in the cultural diversity in leadership (Kelly, 2006). A focused effort on valuing diversity at the senior leadership level is still greatly needed. Given the current state of health care leadership, the representation of diversity to include Black women at the senior-most leadership levels is woefully nominal (Clapp, 2010; "Diversity and disparities," 2012; Kelly, 2006; Pace, 2018; Rich, 2013)

## Significance of the Study to Leadership

In leadership, being viewed as a trustworthy leader is a significant characteristic. Trustworthiness (credibility) as defined for this study reflected an observable, measurable, and teachable set of behaviors and attitudes; reflecting the dimensions of competence, integrity, goodwill and transparency (Ambrose, 2009). When used together, the four dimensions of trust determine if a leader is credible, and therefore worthy of being followed by others. Such leadership behaviors encompass the expected requirements of managers to effectively lead people while upholding ethical values and strategically navigating the demands and changes of their organization's priorities.

To effectively operate as a transformational leader in an organization, the individual should display specific characteristics (Clapp, 2010; Friedman, 2000). Trustworthiness is one such characteristic. Some additional leadership characteristics one should display include being a visionary, charismatic, willing to sacrifice for others, demonstrate courage and exceptional confidence (Friedman, 2000). Taking an introspective look at one's leadership characteristics

may result in a person finding increased confidence in their work, greater visioning, stronger belief, and an overall improved value system. Trustworthy leadership behaviors are needed to effectively manage organizational values, internal demand, and transformational evolution (Caldwell & Hayes, 2007).

Ensuring diversity and inclusion at the senior leadership level of an organization should be a priority. Diversity as a strategic priority contributes significantly to leadership. Diversity including race, gender, thought, experience, education, culture, should be reflected around the senior leadership table for true inclusion in the decision-making process. Being culturally competent in a diverse and inclusive workplace should start at the top of the organizational structure and White male leaders in organizations should understand and prioritize to support future success. Today more organizations are attempting to create cultures that support diversity and inclusion by respecting individuality, developing and utilizing each employee's differences to establish their organization's interpersonal strength and competitive advantage. Although the effort is there, effective strategy for long-term sustainability is lacking. Gender diversity is one of the many glaring opportunities for improvement at senior leadership levels ("Women in Corporate," 2019; Pace, 2018). The focus of this study provided Black women the tools to self-assess allowing for focused preparation for career progression when succession plans are appropriately established to allow such opportunity.

As this qualitative descriptive case study focused on self-awareness, the resulting data helps to enhance the identified characteristics of a transformational leader. Participants completed a self-assessment using the ITP instrument (see Appendix B) and responded orally to interview questions (see Appendix D). The responses based on the four behavioral dimensions of trustworthiness reveal important information that, when examined, revealed key personal

performance strengths that support as well as vulnerabilities that hinder leadership advancement opportunities. The four measures of trustworthiness are quite significant to leadership. Being able to assess self should be a high priority for any leader. This opportunity for self-reflection allowed for more effective preparation for senior management roles. Measuring oneself in the areas of competence, integrity, goodwill and transparency, can be central to leadership development; hence, the significance of this study to leadership.

## Nature of the Study

This study was a qualitative descriptive case study with a narrative analysis of a questionnaire and interview responses. The data for this appreciative inquiry was collected using open-ended interview questions and a self-assessment questionnaire. Qualitative research focuses on the human side of discovery through research (Creswell, 2013). Qualitative research is generally defined to mean research resulting in clear findings not derived via numerical processes or quantifiable data (Strauss & Corbin, 1990). Qualitative research produces conclusions derived from real-world settings that reflect descriptive natural occurrence (Patton, 1990).

Qualitative researchers use a true-to-life approach that seeks to understand phenomena in context-specific settings. Patton (1990) described this as actual situations where the researcher does not attempt to manipulate the occurrence of interest. Alternative research methods were given consideration; however, each seemed to be less appropriate than the selected case study approach. The case study approach was appropriate for this type of descriptive study. There are several methods of data collection when using case study research, including interviews, observation, documents, and questionnaires (Creswell, 2013). As described by Soy (1997), the questions used in a case study focuses on specific events or situations and how they relate.

A case study, like most research, seeks to answer questions, particularly about a specific situation (Creswell, 2013). The case study approach looks at theory and forms additional thoughts from there (Soy, 1997). Ultimately, the researcher is trying to establish a new theory or even challenge an existing theory (Soy, 1997). As this researcher explored and began to describe a possible phenomenon for Black women, the study outcomes have been shaped to answer specific questions about the topic of leadership trustworthiness. As such, this design reflected a reliable approach for answering critical questions about a particular research study through sampling, then presenting the overall findings.

A mixed-method study was given consideration. A mixed-method sequential explanatory research design would allow for the collection of data with a survey followed by interviews. As explained by Creswell (2013), this design features the collection and analysis of quantitative data followed by the collection and analysis of qualitative data. This approach is for use when seeking to gather and examine data that is quantitative, which is then supported by qualitative data. The mixed method is the concept of using multiple methods to produce and evaluate different kinds of data in the same study (Creswell, 2002).

The quantitative aspect of this study is present in the analysis of the data collected from the ITP questionnaire. A quantitative method emphasizes measures and numbers (Creswell, 2013). Merriam (1998) indicates that the qualitative method should be used to capture data with a tool that is sensitive to the core significance when collecting and interpreting data. Quantitative approaches also use descriptive, experimental, or causal-comparative methods (Leedy & Ormrod, 2001). Creswell (2002) suggested that mixed methods research is an excellent design to use when seeking to build on the strengths of both quantitative and qualitative data.

Consideration was also given to the experimental approach. An experimental approach was considered as a means of evaluation, but the method would not allow for an adequate focus on the unique perspectives of the individual participants (Adams, & Lawrence, 2019; Russon & Reinelt, 2004). Numerical data are foundational for quantitative analysis with standard processes (Neuman, 2003). The use of qualitative or quantitative independently would not allow for a full assessment of the current study participants' views. The quantitative research method would provide only one aspect of the needed data for this current study of Black female leaders. Although quantitative analysis was the examination of the data collected, analysis of data from survey responses would not have presented enough data to support this current study. Because of this possible limited data, interviews focused on participant's experiences were included in this case study approach.

Qualitative method was the most appropriate approach for this study versus quantitative. This approach allowed for the exploration of lived experiences and self-assessment versus an extensive data collection process through a survey (Cooper & Schindler, 2008; Creswell, 2002). In qualitative studies, the researcher has a greater reliance on the outlook of participants, using expansive common questions to gather data from participants (Creswell, 2002). The researcher will then examine and explain outcomes based on commonality from the inquiry process (Creswell, 2002).

This current study had a smaller sample size. Given how data were collected for this qualitative case study, combined with the purpose of the study, and even the demographics of the target population, the smaller sample size was most appropriate. The number of participants for this study was limited to 20 with effort to acquire more through the snowballing approach. A

minimum of 20 Black females in health care was set. The participants were from various health care organizations in and around Boston, Massachusetts.

A quantitative study emphasizes measurement, while a qualitative method focuses on a descriptive context that an individual provides, which is based on that person's personal experiences (Merriam, 1998). The research design used for this study was most applicable because the researcher attempted to gather and present data that represented various views of the needed components for effective leadership among a specific group of individuals. Their self-assessment, combined with the description of experiences, was necessary for the most impactful results to demonstrate hindrances for Black women to advance in leadership. The results of this research will help further the study of leadership and offer insights for future studies of African Americans as leaders.

## Research Questions

The purpose of this qualitative descriptive case study was to identify the self-imposed barriers of Black women's opportunities to attain senior leadership positions in health care organizations and provide recommendations for overcoming such obstacles. The following research questions guided the study:

**RQ1.** What is the self-perceived (how they view themselves) level of credibility of Black women who desire higher levels of health care administrative leadership as measured by the four dimensions of trustworthiness? The Black female participants of the study may indicate they see a lack of trustworthiness (credibility) based on how they view themselves. This study seeks to understand if this self-perception results in self-doubt, which in turn leads to stagnation in advancement opportunities.

**RQ2.** How does the perception of trustworthiness influence self-doubt and the potential for leadership advancement for Black women in health care administration? By hearing firsthand from Black women who desire to be in higher levels of health care administrative leadership, there will be robust data available for future studies. Past studies have focused on what leadership in organizations can do to be more inclusive (Thomas & Gabarro, 1999). This study will focus on self-reflection to assess if such internal factors influence the suggested glass ceiling (Hyun, 2005) that limits opportunity.

**RQ3.** Are there solutions that can be provided based on the Black women's experience in obtaining their role in health care administration as viewed through the lens of the trustworthiness using the four dimensions of trust? As the study of leadership continues to evolve, understanding the perspective of minority leaders may provide insight into the limitations that block their advancement.

## Theoretical Framework

The theoretical framework of this study is a human science approach to gain a greater understanding of leadership. Utilizing an inquiry method, leadership behaviors and abilities needed for individuals to be transformational leaders were assessed. The study of leadership lends itself to opportunity for contribution from various perspectives, including self-assessment. The view of this researcher focused on the self-efficacy of Black women who desire to obtain executive administrative leadership positions within health care. The theory of transformational leadership foundationally reflects a style that transforms organizations and motivates followers to become influential leaders (Bass & Riggio, 2008). This researcher intended to examine how leadership advancement is influenced by self-perception. Black women as executive administrative leaders could result in them being viewed as transformational leaders capable of

leading positive organizational change. The theory of transformational leadership is an influential style that impacts change (Wenig, 2004). The influence of Black female leaders in health care could have a significant impact on health care services to meet the needs of African Americans in the community and thus possibly reducing health care disparities (Grant, 2010).

Leadership continues to evolve, and there is hope that this study contributes to understanding why there remains a lack of representation of African Americans in executive senior leadership positions, particularly Black women in health care senior level leadership. There continues to be a struggle with responses to inquires of how to increase diversity in executive leadership (Gauss, 2012; Grant, 2010; Pace, 2018; Thomas & Gabarro, 1999). Some might consider the focus of this study shifts from the real issues that hinder advancement, as indicated by historical facts of discriminatory hiring practices, particularly those things that initiated Affirmative Action (Thomas & Gabarro, 1999).

This study did not focus on there being a lack of desire or externally imposed barriers that reflect inequalities; however, the results show these are two important dynamics of concern. The need for regulations through public policy to ensure equality in various ways is now a clear governmental expectation. Although there is validity with such traditional rationale to inequality resolution, the self-imposed factors are present as well as a result. Self-perception of trustworthiness in some ways limit Black women from advancement opportunities to higher-level leadership positions. The theory of transformation leadership requires leaders to be credible, and credibility begins with self (Bass & Riggio, 2008).

There are many traits to describe a successful leader. Leadership traits can be different based on the person in the leadership role as well as those who view them as a leader. The traits being assessed in this study are competency, integrity, goodwill and transparence. The

assumptions that support these traits when examined more closely help determine development opportunities for the Black women who participated in this study. It also provided guidance for future aspiring leaders to consider as they progress through their careers. These traits are measurable using the four dimensions of trust.

The four dimensions of trustworthiness are foundational to successful leadership and, in some ways, important in other studies as well (Thomas & Gabarro, 1999). Any self- assessment lays the foundation for successful leadership. For this study, self-assessment required examination of the four dimensions of trustworthiness. The review of self-equips an individual to meet the needs of followers. Followers expect trustworthy leaders (Ambrose, 2003).

Some might argue that the dimensions of credibility should be developed early on in a person's leadership career (Thomas & Gabarro, 1999). Once an individual reaches midlevel management, Thomas and Gabarro (1999) indicate that robust leadership competencies should be in place. This study shows that there is still an opportunity for assessment and adjustment to prepare for higher-level leadership positions. Through self-assessment of credibility, aligned to transformational leadership theory, individuals were able to identify the dimensions of trust that reflect self-imposed hurdles. Such walls may be hindering African Americans from the recognition of being trustworthy transformational leaders in administrative health care leadership.

## Definitions

For this qualitative descriptive case study, credibility and trustworthiness were used interchangeably. The key terms of this study are referenced as the four dimensions of trust include transparency, competence, goodwill, and integrity. The definition and detailed

description of the words are reviewed in Chapter 2. Below are the descriptions or contextual meaning of additional terms that are used throughout this study:

**Black female/woman.** The name Black woman or female is being used to describe individuals who self-identify as members of the Black or African American race and female as traditionally defined by the Equal Employment Opportunity Commission (EEOC) within the Department of Labor (www.dol.gov).

**Healthcare organizations.** The term health care organization is one that provides services to individuals for the prevention, treatment, and management of illness. For the intent of this study, health care organizations will have a minimum of 50 employees and are located within a 25-mile radius of the city of Boston, Massachusetts. The use of health care as two separate words would not be appropriate for this study as that would refer to the direct service provided to a patient by a provider.

**Leader.** Someone who can create a compelling vision that takes people to a new place and the ability to translate that vision into action (Bennis & Goldsmith, 1997).

**Leadership.** An interaction between two or more members of a group that often involves a structuring or restructuring of the situation and the perceptions and expectations of the members (Bass & Riggio, 2008).

**Manager.** A person, who plans, organizes, leads, and controls the work of others so and organization can achieve its goals (Dressler, 2002).

**Trustworthiness.** The degree to which an individual is worthy of confidence as measured by four dimensions: competence, integrity, goodwill and transparency (Ambrose, 2003).

**Self-assessment, self-efficacy, self-identified.** These three terms describe the process of and resulting data for how managers view themselves using the four dimensions for measurement of trustworthiness (Murray, 2003).

**Transformational leader/leadership.** Transformational leaders are change agents who transform organizations through the engagement of followers; while helping to shape others as influential leaders (Bass & Riggio, 2008).

## Assumptions

Participating in this study were individuals who at some point in their career want to move to senior leadership positions, had the desire to influence others and met the minimum educational and experience requirements to be in the desired leadership role. This study focused on individuals as transformational leaders. Transformational leaders want to produce other great leaders, but this will only happen if there is a demonstration of the needed behaviors of successful attainment of a leadership position (Northouse, 2004). A person who acts out of goodness serves as an inspiration to others and focuses on doing the good or right things (Watson & Rosser, 2007). Inspirational leadership factors were revealed as this study looked at the goodwill factor of trustworthiness. As a leader, self-examination will help with this process of skill development that allows for the influence of others.

This researcher assumed that participants provided honest responses to the interview questions. The questions in the study were focused on the participants' perception of credibility. The self-assessment was based on the ITP (see Appendix B) and the interview questions (see Appendix D) that were open-ended, focused on the lived experiences of each participant.

Integrity was also one area of focus for this study, asking respondents for candid answers in this category. Participants may be more truthful when responding to an anonymous survey

(Leedy & Ormrod, 2001). In this research study, participant's responses were anonymous, so there is an assumption that participants responded candidly and honestly.

## Scope of the Study

The focus of this study was on the impact of self-perceived trustworthiness of aspiring Black female leaders' ability to access senior administrative leadership positions in health care. Consideration was given to the four dimensions of trustworthiness: competence, integrity, goodwill, and transparency to determine the extent to which Black female managers viewed these as necessary, and how aspiring leaders saw themselves across the dimensions of trust in alignment to transformational leadership. Participants consisted of 20 Black female managers from health care organizations in and around Boston, Massachusetts. For this study, participants selected were between ages 25–55 years. Participants met following criteria: Black female managers or aspiring managers who: (a) work in a health care organization with a minimum of 50 employees serving a diverse client population, (b) have an expressed interest in health care senior administrative leadership, (c) have been in their health care midlevel administrative position with at least 3 direct reports and or health care services role for a minimum of 2 years without direct reports, (d) minimum education level of a Bachelor's degree.

## Limitations and Delimitations

A limitation of this study was difficultly in controlling whether participants provided honest responses in their interviews, resulting in jeopardizing the strength of the data. Several measures were taken to elicit frank and accurate answers. These measures are presented in the methodology section of this dissertation.

A second limitation was the geographic demographics. The study was limited to participants in the Boston area. Like any other region, Boston has its unique socio-political

climate regarding racial integration, immigrant patterns, and additional factors. These are all factors that may have skewed the population in favor of access to one racial group over another. This study did not control for such considerations.

A third limitation might have been the Black females who were invited to participate in the study being offended by the focus of the studying. This legitimate concern was related to focusing on their self-assessment to identify possible reasons for limited leadership advancement opportunities. The historical challenges faced by many Black women in America due to well documented inaccurate stereotypical, derogatory and unfair treatment was thought to be the expected focus for a study of this population of Americas (Ashley, 2014). The derogatory references and devaluing of the contributions of Black women in the workplace is a reality, and was not underestimated or ignored, however there may have been other factors to consider from a self-imposing lens resulting in a lack of advancement opportunity. The personal perspective and experiences of this researcher helped ensure this unfortunate reality was not excluded from the outcomes of this study.

The final limitation was the small numbers of Black female leaders currently in health care organizations in the Boston area willing to participate in a study. African Americans represent less than 5% of leadership positions in health care organizations nationally ("Diversity and Disparities," 2012; Gathers, 2003; Hellinghausen, 2000). This data is in sharp contrast to the highly diverse patient population served by these executives. This data is assumed to be reflective of African American health care executives in the Boston area as well.

The delimitation of this research was the sample population, which consisted of Black females in a specific age group and a minimum number of direct reports. The intent was to explore and describe the self-identified behaviors of Black females with entry level to midlevel

administrative health care backgrounds. This restrictive target population allowed for a narrow lens into the contentious topic of diversity in health care leadership.

## Chapter 1 Summary

Chapter 1 explained the importance of Black women identifying the self-imposed barriers that hinder the opportunity for advancement to executive health care leadership positions. The purpose of Chapter one was to introduce the topic of there being a lack of Black women in health care leadership and describe the purpose and problem statements, the nature, and the significance of the study to leadership.

Executive health care leadership is facing significant challenges with diversity and inclusion (Herrin et al., 2018; "Diversity and Disparities," 2012; Sullivan, 2004). Health care disparities exist just as limited African Americans in health care administrative leadership exists ("Diversity and Disparities," 2012). Adequately reflecting diversity in leadership may contribute to the well-being and health care of the diverse patient population in the future (Sullivan, 2004), ultimately reducing health care disparities. A clear understanding of the reasons for Black women not being equally represented in senior-level health care administration based on self-imposed barriers contributes to increased presence of this subset of the African American community at the decision-making table. Coherent recommendations to address the obstacles may also add significantly to the health care needs for the Black community in the United States.

Chapter 1 explained the importance of a study of the self-perception of Black women in the area of credibility based on four dimensions, competence, integrity, goodwill, and transparency. To help shape and enhance this study, Chapter 2 contains a review of related literature focusing on the trustworthiness of Black women as leaders in health care organizations,

African Americans as leaders, transformation leadership, and discussion of other key leadership components.

Chapter 2

Review of the Literature

Chapter 2 establishes the groundwork for examining aspiring Black women's self-assessment of their leadership credibility in their career journey to senior leadership positions. This study leverages a survey tool and an interview guide focusing on the four dimensions of trust. This researcher proposes the results may support the thought that self-assessment may reveal self-imposed impacts on a Black woman's ability to attain a higher-level health care administrative leadership position. This analysis investigates the effects of the participants' self-assessment of their own credibility as leaders. The population under study is Black female managers in health care organizations.

This literature review provides background into the published writings regarding Black women in health care leadership. Chapter 2 also provides a supportive theoretical construct for the concepts related to the analysis of Black women as leaders. This study explores theories that support the case of credibility and leadership. This researcher also explores the core aspects of the challenges facing Black women who aspire to be in higher levels of leadership. These challenging aspects may be intrinsic or extrinsic factors that impact opportunities for advancement. Lastly, the study presents the concept of leadership competencies to highlight leadership expectations in health care organizations. It is essential to understand the literature as well as the lack of literature available regarding trustworthiness, Black women in health care leadership, Black women in leadership, and self-assessment for Black female leaders.

## Title Searches and Documentation

The search of the literature initially resulted in limited data on African Americans in health care administrative leadership. A subsequent search with a narrower focus on Black

females provided even fewer results. Limited data is also available on the self-perception of African Americans in the area of trustworthiness. The literature search for this study uses the Google Scholar database, Amazon Books, University of Phoenix library database system, which includes ProQuest, Emerald, and EBSCOhost databases, among others. As this researcher seeks to identify Black women's self-perception and possible limiting self-doubt, the search terms include Black women in leadership, Black women in health care leadership, Women of color in leadership, Leadership credibility, African American leaders, the trustworthiness of African Americans, the credibility of African American leaders, self-perception of African American managers, African American executives as leaders, diversity in health care leadership, minority leaders, dimensions of trust and credibility. Review of available data shows limited information on how Black women view themselves as leaders; however, more information is available on how others view them in the workplace. There is also significant data on the lack of diversity at the executive level across various industries in the United States.

A review of the literature indicates there is a gap in available data on African American leaders, particularly in health care administration and minimal data on Black women in health care administration. There is an insufficient amount of data available that specifically discusses African American leaders in health care, trustworthiness as a needed leadership trait, and the self-perception of credibility. Little to no data is available on Black women in health care leadership and the challenges faced due to imposed factors, including racism and sexism. Due to the limited documented information regarding Black women in health care leadership, for the purpose of this literature review, there are references to African Americans, women and minority groups, all of which Black women are a part of in the United States.

Between the mid-1980s and 2005, there are several studies on what is termed, breaking through the glass ceiling, and the barriers faced by women and minorities in the workplace is (Hyun, 2005; Marrujo, & Kleiner, 1992; Thomas & Gabarro, 1999). There is scarce scholarly information available 2004 – 2019. A broader search using the topic, diversity in health care leadership, results in more study since 2000 to support the fact there are limited female and minority representation at highest levels of leadership in health care organizations (Clapp, 2010; "Diversity and Disparities," 2012; Elias, 2018; Gathers, 2003; Gauss, 2012; Grant, 2010; Hellinghausen, 2000; Rich, 2013; Rosenberg, 2008; Wolliston, 2008). When focused on Black women in health care leadership, results point to the combination of racism and sexism as direct limiting factors (Davis, 2018; Pace, 2018; Thew, 2019; Williams & Multhaup, 2018; Wolliston, 2008).

The analysis of literature utilizes primary and secondary sources from 25 books, 70 peer-reviewed or scholarly journal articles, and 10 other professional or government publications. Chapter 2 outlines these sources in topical sections: Historical including Black women in health care leadership, Credibility (Trustworthiness), Credibility of Black women as leaders; and Current Findings including Leadership, Leadership Credibility and Self-assessment, Leadership Traits and Theory, Transformational Leadership, Black women in Healthcare Administrative Leadership, Black women as Senior Leaders, and Diversity in Healthcare Leadership. There are limited resources related to the topic of Black women in health care leadership. Only, 25% of the books, articles and publications for this current study are from sources less than 5 years old in April 2020. Given the limited available resources, 12% of the books articles and publications are sources 6 to 10 years old in April 2020.

The review of the available research was conducted in the following categories: (a) peer-reviewed journal articles, (b) early-stage materials, and (c) books, and (d) reports. Given the limited research data available, additional non-peer reviewed resources are referenced. The topics, concepts, and theories were reviewed to the extent to which they are relevant to this study.

## Historical Overview

There is a lack of Black female representation in health care leadership (Bland, 2019; "Diversity and Disparities," 2012; Grant, 2010; Pace, 2018; Rich, 2013; Rosenberg, 2008; Sullivan, 2004; Thew, 2019). Given the diverse patient population, decision-makers in health care organizations should be reflective of the same diversity (Bland, 2019; Sullivan, 2004). The problem identified in this study focuses on the Black female midlevel leader in health care organizations and the self-imposed barriers that may hinder their advancement to higher-level leadership. It is essential to understand the literature or the lack of literature available regarding trustworthiness, leadership in health care, Black women in leadership, and self-assessment for Black female leaders.

Women have what it takes to lead in the workplace and the desire (Pace, 2018; Rothman, 2019; Sandberg, 2013). There have been strides for women in leadership over the past fifty or more years, however, the number of men in leadership continue to significantly out-number women (Miller et al., 2016). Studies show there have been increased efforts in demonstrating the presence of women in leadership; however, less effort is on people of color (Charlton, 2019). Even with the lack of leadership support, Black women in senior leadership roles do exist in corporations across America ("Most Powerful Woman," 2019). The numbers are low. Black,

Hispanic and Asian women make up fewer than 3% of board directors of Fortune 500 companies and fewer than 4% executive management (Miller et al., 2016).

Many Black women are seeing levels of success not seen in the past for their demographic populace in the workplace. Review of the literature on career progression shows that in health care administration, Black women, who are considered members of the African American population, have been afforded opportunities at the midlevel management level but less often have had an equal opportunity as Whites for higher levels (Bozman, 1988; Pace, 2018; Rich, 2013; Shinew & Hibbler, 2002; Thew, 2019). Reasons for this lack of opportunity focuses on discriminatory practices, lack of mentoring, and a lack of recruitment effort (Shinew & Hibbler, 2002). Williams and Multhaup (2018) suggest a lack of fairness in work distribution as a reason. According to Thomas and Gabarro (1999), 95% of executive-level leadership positions in the United States are held by White males. Nearly 20 years since the data presented by Thomas and Gabarro, the numbers have only moved minimally. Larson (2006) posits that African Americans have limited advancement beyond the midlevel manager in health care organizations. Kelly (2006) also documents that in health care management roles, minorities are underrepresented. Additional research shows the higher the positions in the organization, the fewer racial and ethnic minorities represented. (Bland, 2019; Kelly, 2006; Larson, 2006; Pace, 2018; Rich, 2013).

The U.S. Bureau of Labor Statistics (2015) reports that members of minority groups would make up 41.5% of all people entering the U.S. workforce between 2014 and 2024. The report also indicates the growth rate for Blacks between 1996 and 2006 was 14%, reflecting a higher percentage than Whites (2015). Future studies of the topic of disparity in leadership could focus on 41.5% of minorities and their experience and unseen opportunities for leadership roles.

According to a 2011 benchmarking survey, fewer than 15% of hospital boards, executive leadership positions, and midlevel leaders reflect minority representation ("Diversity and Disparities," 2012). Could the lower numbers of minorities in senior-level positions in health care organizations be attributed to a lack of desire, confidence, or ambition? Studies suggest that company culture may be the reason over their ambitions or confidence levels (Devillard et al., 2014; Williams & Multhaup, 2018). Black women do not lack the ambition to become senior leaders they lack opportunity (Pace, 2018). Senior leadership opportunities in health care administration for Black professionals are different from their non-minority counterparts (Grant, 2010; Livingston, 2018; Rich, 2013). Black leaders are under-represented at the senior decision-making level based on external contributors as well as self-imposed factors (Grant & Sumanth, 2009).

The history of African Americans in the United States provides the most dominant external factors of discriminatory practices reflected in the workplace (Jackson, 2004). Before Franklin Raines was appointed CEO of Fannie Mae in 1998, there were no CEOs of African American descent in Fortune 500 companies (Thomas & Gabarro, 1999). Since Raines' appointment, there remained a lack of equality for African American's opportunity to attain the highest level of leadership in organizations, even with the rise of some additional African Americans to the executive level of their respective organizations (Dyrda, 2019). This same disparity is reflected in health care leadership ("Diversity and Disparities," 2012; Grant, 2010). Given the discovery of limitations in research, the literature does not indicate self-perception of trustworthiness or credibility as a reason for this lack of representation. This lack of available data indicates a need for this qualitative descriptive case study.

Although there is limited information available on the self-perception of Black female leadership credibility, a review of literature provides foundational information supporting the importance for trustworthiness as a competency in leadership. Maxwell (2007) indicates that trust makes leadership possible. The leader's behavioral nature establishes trustworthiness among employees (Ambrose, 2003). Diversity of thought that comes from diverse leaders can also be linked to trust as employees experience more excellent dialogue and communications from this type of leader (Grant & Sumanth, 2009; Rich, 2013).

The study of available literature results in limited research studies identifying the link between self-perception of trustworthiness and access to senior decision-making leadership positions for Black women in health care executive leaders. This literature review focuses on trustworthiness or credibility as a factor in choosing leaders. Kouzes (2003) posits the foundation of leadership is credibility. Without a strong person delivering the message, the followers will not believe the message (Kouzes, 2006). Such qualities might be revealed for participants in this study as they complete the ITP (Ambrose, 2009) and respond to interview questions. The self-assessment questions from the ITP and interview will obtain data on how study participants view themselves. The open-ended interview questions gathering details of their experience may provide insight into how their view of self contributes to their career progression.

Being a trustworthy leader results in trust from followers (Kiyonari et al., 2006). Ascertaining how trustworthiness connects to transformational leadership may provide valuable information on what capabilities Black women should possess to reach senior leadership levels. Identified gaps in the literature of how this subgroup of African Americans seeking higher-level management positions may view themselves in the area of credibility as transformational leaders will provide the theoretical framework of this research study. This researcher will demonstrate

how the self-perception of Black women's trustworthiness (credibility) on four dimensions of behavior (competence, integrity, goodwill, and transparency) may impact the individual's confidence, creativity, performance, and most importantly leadership opportunities. Using the ITP (see Appendix B) as a tool as well as leveraging the tool as a guide for the interview questions (see Appendix D), the researcher seeks to determine the degree to which Black women who aspire to health care senior leadership positions view themselves as trustworthy (credible) based on these four dimensions of behavior (Ambrose, 2009).

Thomas and Gabarro (1999) indicates that career development and planning for professional advancement is in the hand of the individual. The study conducted by Thomas Gabarro focuses on minority executives and the factors that contribute to their career progression. As African Americans attempt to ascend to executive leadership, identifying the needed skills and behaviors will help ensure they possess the appropriate leadership qualities. Women in leadership have a significate opportunity for continued study of behaviors reflective of female leaders who have ascended to senior leadership roles. Elias (2018) shares lessons learned and recommendations from women leaders of non-Fortune 500 companies on their rise to success. This study by Elias of women leaders does not look at the specific behaviors of women of color, which further supports the need for this current study of Black women.

Identifying a specific leadership style is an essential aspect of this study. Style identification provides additional development input for Black female midlevel leaders in preparation for movement to higher levels of leadership. For the intent of this study, the style of transformational leadership is referenced to discuss leadership characteristics (Bass & Riggio, 2008). There appears to be a gap in the literature concerning African Americans, Black females, being viewed as transformational leaders. A focus on African Americans, specifically Black

women, as transformational leaders may be an area for consideration to further the study of leadership in the United States. The focus on African American leaders as transformation leaders can be viewed as necessary, as was demonstrated in the 2008 election of Barack Obama as President of the United States. President Obama is considered a transformational leader (Kyle & Price, 2009). A focused study on Black women as transformational leaders can be the focus of future studies.

There is research support for the lack of equality between African Americans and Whites in leadership roles in the United States (Gathers, 2003; Jackson, 2004; Rich, 2013; Williams & Multhaup, 2018). There is also specifically a lack of diversity in health care leadership ("Diversity & Disparities," 2012; Livingston, 2018; Rich, 2013). Given the diverse patient population, decision-makers in health care organizations should be reflective of the same diversity. The problem identified in this study focuses on the Black female midlevel leader in health care organizations and the self-imposed barriers that may hinder their advancement to higher-level leadership.

Individual assessment of one's leadership is essential (Ambrose, 2003; Murray, 2003). The perception of others may be a more significant driver for leadership advancement; however, this researcher asserts that self-perception may be a driver or hindrance to leadership advancement as well. The four dimensions of trustworthiness, as defined by Ambrose (2009), provide a solid foundation for leadership competency assessment. These areas of focus align with the purpose of this study. Since there is a gap in the literature regarding African Americans' self-perception of trustworthiness, there is a clear need for this study. This qualitative case study will use a narrative analysis of semistructured interviews focusing on Black women's self-perception of trustworthiness and how that hinders or supports advancement to leadership

positions in health care. This study is helping to address the identified lack of minority leadership in executive health care leadership (Pace, 2018; Thew, 2019).

**Black Women in Healthcare Leadership**

Providers of direct patient care, as well as senior-level leadership roles in health care organizations, lack representation of Black women (Bland, 2019; Livingston, 2018; Pace, 2018; Seipel, 2018). Black women represent only 2% of more than 800,000 active physicians in the United States (Seipel, 2018). In 2019, there were 68 African Americans identified as senior-level leaders in health care organizations across the United States, with 42 being Black females (Dyrda, 2019). A list reflecting greater than 60% of included individuals being Black females is less impressive when compared to the total number of active U.S. health care organizations reflects thousands of organizations, physicians, and leaders.

Black female nurses face challenges in the workplace that may hinder them from leadership advancement (Bland, 2019; Thew, 2019). The barriers for women of color are disparities, and discrimination that must be addressed. Limitations in advancement opportunities may be due to Black women not demonstrating leadership capabilities. There is also the consideration that being slighted for leadership may be attributed to disparities with the distribution of work that would allow Black women the opportunity to effectively demonstrate their skills and capabilities to ascend to top leadership (Williams & Multhaup, 2018). This current study, however, focuses on the lack of opportunity being a self-imposed lack of credibility. The limited past studies focused on Black women in leadership suggests the additional study of Black women as midlevel leader to understand better their ascension to leadership and their desires for higher levels of leadership is needed (Bland, 2019; Pace, 2018; Thew, 2019; Yancey, 2018).

**Credibility (Trustworthiness) as a Leadership Trait**

Credibility (trustworthiness) is the cornerstone of leadership (Ambrose, 2009). Credibility links to the leader's ability to influence others to achieve the desired future (Halpern & Lubar, 2004; Kouzes & Posner, 2003), and it also determines to a large extent if a person is selected to serve in a leadership position. This ability to influence aligns with the foundational tenants of transformational leadership (Bass & Riggio, 2008; Eurich, 2013). The findings of this study may provide information that shows that Black women are excluded from senior leadership positions because they lack confidence in critical dimensions associated with trustworthiness. Credibility may be ascribed by others but may also be established by an individual based on their self-perception. How minority leaders view themselves as measured by four dimensions of trust will provide the foundation for this qualitative descriptive case study of Black women. The four dimensions are competence, integrity, goodwill, and transparency. Ambrose (2000) describes each dimension as it relates to credibility, as seen through self-assessment.

The first dimension of trustworthiness is competence. Leaders should demonstrate competence in their role. The leader can be relied on by others as they embrace and commit to gaining new knowledge while consistently getting reliable outcomes (Ambrose, 2009). Competence is more than speaking certain things, but it includes articulating, outlining, and doing the work that engages followers (Maxwell, 1999). Key characteristics of leadership competence in health care include knowledge, skills, abilities, and attitude (Pihlainen et al., 2016). When a person is a competent leader, they can consistently set goals and achieve them (Eurich, 2013).

The second dimension of trustworthiness is integrity. Integrity means that a person is honest, keeps promises, and takes action that matches stated values and beliefs (Ambrose, 2009). The leader has responsibility in design, delivery, and upholding and being true to what is considered right (DePree, 1989). People should make choices and live their lives in a way that reflects what they say they believe. In leadership, no one is perfect, but there should be an effort to do what is right in all situations. Emotions, actions, character, and moral habit all come to mind when considering integrity and ethical behavior.

Goodwill is the third dimension of trustworthiness. People want to know that their leader cares about them (Halpern & Lubar, 2003). Goodwill, as described by Ambrose (2009), is demonstrating care for others through actions. Goodwill is vital and warrants consideration of Maslow's Hierarchy of Needs. Maslow's theory is the belief that people have different needs at different times (McShane & Von Glinow, 2000). The theory includes five levels (a) self-actualization, (b) esteem, (c) belongingness, (d) safety, and (e) physiological. When considering the behaviors associated with goodwill, the basic needs of humans will be connected. People want to feel warmth and commitment from a leader (Halpern & Lubar, 2003). Without goodwill, there will be a lack of respect and camaraderie.

The fourth dimension of trustworthiness is transparency. Transparency may be viewed as the most challenging area for minority leaders, as it involves vulnerability. Transparency is "communicating openly and disclosing true feelings" (Ambrose, 2009). Leaders must be willing to expose who they are even at the expense of being vulnerable (Halpern & Lubar, 2003), which would be considered a positive risk in leadership. This openness will in some ways, strengthen others. Establishing an environment that encourages others and gets people involved, establishing a feeling of importance, is at the heart of leadership (Kouzes & Posner, 2003). A

transparent communicator who is willing to self-disclose and share openly will motivate individuals and creates a safe place for others.

**The credibility of Black Women as Leaders**

Credibility is foundational for effective leadership (Grant & Sumanth, 2009). Meaning there is a need for any leader to be viewed as trustworthy. Historically, Blacks have been viewed as less trustworthy than Whites, however, this antiquated generalization is not true (Simpson et al., 2007). Over the years, there have been studies that support the unbalanced reality of superiority (Gathers, 2003; Jackson, 2004). Existing studies conclude that regardless of the factors relating to trust, Blacks are viewed as less trusting than Whites (Simpson et al., 2007). The lack of trustworthiness is a possible reflection of how and why Black women may face obstacles in the attainment of executive leadership positions. The lack of equality and access in American society historically forced minorities to push past the established structure obstacles to gain advancement (Gathers, 2003; Grant, 2010; Stoddard, 1973).

Advancement opportunities remain far less available for Black women than for Whites (DeGroot et al., 2013; Graves, 2019; Jackson, 2004; Pace, 2018). Data reflects that in the early 1960s, more than 60% of the workforce was comprised of White men (Gathers, 2003). By the mid2000s, the percentage dropped to about 40% overall (Gathers, 2003). Although there is more representation of minorities across organizations, the numbers are very different at the midmanager to executive level ("Diversity and Disparities," 2012; Jackson, 2004). In health care organizations, there is an average of 14% of minority executive leaders compared to the 29% minority patient population ("Diversity and Disparities," 2012; Rich, 2013). Based on the review of available literature, there is no clear indication that this is the result of the self-doubt of African Americans.

**Black Women as Leaders**

Out of the nearly three million top executives nationwide, less that 150 are Black women (Graves, 2019). There have been changes in the labor force over the years in America, yet African Americans, which for the purpose of this current study includes Black women, remain underrepresented in leadership roles ("Diversity and Disparities," 2012; Friedman, & DiTomaso, 1996; Graves, 2019).

Changes that have taken place over the years may be attributed to organizations being faced with a forced choice of equality as a result of Affirmative Action becoming a national policy (Friedman & DiTomaso, 1996; Leiter & Leiter, 2011). Affirmative Action requirements for companies to adjust hiring practices put the burden to address the identified need for diversity on the organizations. A greater focus on individual leadership development efforts to break through the barriers to higher-level leadership may contribute to an increase in the presence of minority leaders at the executive leadership level. The results of this qualitative descriptive case study will contribute to this effort by providing new data relating to Black women and their opportunities for executive-level leader roles.

The study of leadership since the 1800s has mainly focused on White males and the fact that African Americans were not viewed as leaders (Bird, 1940; Rosener, 1996). Watson and Rosser (2007) suggest that some believed being effective in leadership is not something African Americans were intellectually competent to do, indicating they could not accurately analyze and assess situations if put in leadership positions. A biased perspective of African Americans, as discussed by Watson and Rosser, links to the identified concerns with standardized testing, which placed limitations on African American students' ability to advance from an educational perspective. The shift from the historical mindset of leadership in America drives the focus on

diversity as a foundational factor for organizational success today. There should be caution when leveraging American history when discussing good leadership as it presents a biased perspective that excludes Black people and other minority groups (Harter, 2015).

There are variables for consideration related to the assessment of Black women's leadership capabilities in relation to the dimensions of trustworthiness. The discrepancy with standardized testing holds true when assessing the trustworthiness of African Americans compared to Whites (Simpson et al., 2007). In early research on trust, the standard trust measure was used and has since been scrutinized based on concerns with the results reflecting that African Americans are less trusting than Whites (Watson & Rosser, 2007). Measures used may not reflect an accurate predictor of trustworthy behavior (Simpson et al., 2007). This study expects that there will be robust data to reflect the self-perception of a set of African Americans on their self-perception of credibility. There are negative pejoratives about Black women and even among the small percentages of Black female leaders in health care for other obvious reasons (Ashley, 2014; Seipel, 2018); there may also be reasons that require self-reflection through an open and honest self-assessment.

Tate (2008) postulates that little research examines the variables contributing to leadership outcomes; however, the study does establish that the perception of leaders by others shows variation over time. The focus of this current study is on self-perception, specifically on how Black women perceive themselves as leaders. The review of available literature does not suggest the attainment of goals is hindered by how Black people view themselves. Black people battle against the dual challenge of disproving stereotypes related to their ability to lead while controlling their self-doubt and discomfort with being in leadership (Ashley, 2014). Being true to oneself versus fabricated images created by others should be what drives the effort for

advancement (Ambrose, 2009). The appraisal of one's knowledge, skills, and abilities are crucial to the pursuit of higher-level leadership. Self-assessment will enable people to make choices to better prepare for promotional opportunities (Thomas & Gabarro, 1999).

African Americans who desire executive-level leadership roles will need to demonstrate leadership credibility (Ambrose, 2009). Trustworthiness as a leadership trait is the foundation of this study of Black women in health care leadership. In the current state of workplace challenges faced by all women, there is a need to focus on re-building credibility (Schipani & Dworkin, 2019). Trust, which takes time and patience, is part of this important leadership trait. This process may be reflected with self-perception as well as the actual views of others. For African American leaders, the time needed for the building of trust and being trustworthy may be magnified as a result of poor treatment, as documented in United States history.

In addition to the identification of leadership credibility, individuals should identify their leadership style (Ambrose, 2003). For the purpose of this current study, the comparative leadership style is that of transformational leadership. When considering the dynamics of leadership, trust is a required character trait (Ambrose, 2003; Burns, 1978; Yang, 2016) that is a characteristic of transformational leadership. If there is no trust, there will be no followers. Transformational leaders display confident and reflect the four dimensions of trustworthiness as defined in this current study. President Barack Obama demonstrated the characteristics of a transformational leader during his rise to the presidency reflecting that which is possible for other Black people in America. President Obama has set a new standard for African Americans' desire and ability to reach higher levels of leadership (Kyle & Price, 2009).

## Current Findings

### Leadership

Today's workplace is characterized by continually changing dynamics. Now, more than ever, leadership is a critical factor in organizational success. Rosener (1996) indicates that American corporations are patterned after the church and the military. Corporations are hierarchical and characterized by top-down decision making, and a command and control style of leadership associated with male attributes (Rosener, 1996). This way of thinking is slowly becoming extinct, and there is a higher value on diversity. There is a value add to any organization considering diversity as a number one priority (Charlton, 2019; Rothman, 2019). The value of diversity could be viewing the impact of differences in leadership styles, problem-solving, conflict resolution, motivation, and the overall service or products provided to customers, as pivotal for organizational success (Rosener, 1996).

According to Thomas and Gabarro (1999), 95% of executive-level leadership positions in the United States are held by White males. Rosener (1996) indicates that leadership ability favors the values and behaviors of White males as based on a historical model that assessed performance and leadership potential. As society has advanced in this area by including more women, positive results are seen, and this antiquated model is being used less often (Charlton, 2019; Rosener, 1996). There are small numbers of minorities in leadership positions, and there is data that continues to surface to support the added value of such a shift in thinking (Charlton, 2019; Rosener, 1996; Thomas & Gabarro, 1999). Research about and conducted by women and people of color is growing with value add from this often-silent voice in organizational leadership (McGee Banks, 2000; Pace, 2018).

Larson (2006) suggests that African Americans have limited advancement beyond the midlevel position in health care organizations. Kelly (2006) also documents that in health care management roles, minorities are underrepresented. Racial and ethnic minorities are prominent at lower levels in organizations while research shows that the higher the positions the less representation (Charlton, 2019; Kelly, 2006; Larson, 2006; Pace, 2018; Rich, 2013). In all organizations, there is a need for stable leadership that reflects knowledge and understanding of the communities served as well as the foundational knowledge of their industry and leadership skills. Leadership should demonstrate knowledge that can have a positive impact on employees, customers, and stakeholders with the most significant consideration given to customers.

The idea of a leader was formed long before a meaning was attached to the word (Fullan, 2000). Leadership is the process of persuasion inclusive of many styles and qualities (Fullan, 2000). If surveyed, people would likely identify with a different definition of what leadership means. Tichy and Cohen (1997) describe leadership as a process of influence of one person to others to achieve objectives. An interconnected and intelligible organizational environment reflects its leadership (Tichy & Cohen, 1997). Reviewing the definition that Tichy and Cohen cite, requires a pause for reflection upon the long-held leadership assumptions in order to gain an understanding of the full spectrum of leadership today. Differences exist and are a value add to successful organizational leadership (Clapp, 2010; Harter, 2015).

Although there still seems to be a gap between the recognition of the need for diversity in leadership and the realization of the potential for vastly positive results if embraced, which is progress, and the gap is not as wide as in the past (Jackson, 2004). There have been strides that reflect leadership that is more culturally diverse; however, there remains a lack of balance in

health care given the diverse patient population ("Diversity & Disparities, 2008; Jackson, 2004; Rich, 2013).

The fact that there are different cultures is a clear indication that there are always differences in the core elements of what leadership should reflect (Watson & Rosser, 2007). Different does not mean bad or even negative; it is merely different. Due to the nature of leadership, there are more similarities than differences between cultures. Effective leaders usually want the same thing, and the competencies of fundamental leadership practices needed to achieve results, tend to be the same (Kouzes & Posner, 1997). Cultural background is what gives diversity and uniqueness in any field, especially leadership (Hyun, 2005). As society moves from a closed-minded mentality to a more open mindset, there appears to be a rise in the cultural diversity in leadership even with the differences that naturally present (DeGroot et al., 2013; Hyun, 2005).

The definition of effective leadership can differ depending on culture, however, there are more similarities in the definitions than differences (Robie et al., 2000). A study of cultural leadership focusing on comparing the U.S. and European managers from different countries on the perceived competencies required in their current position demonstrates this similarity (Robie et al., 2000). The study also presents the relations between the competencies managers currently possess to various managerial outcomes (Robie et al., 2000). This focus on cultural competencies provides support to the idea that there are certain differences in leadership effectiveness based on culture; however, there are also several similarities. In alignment with this current study of Black women's self-perception of credibility on the dimension of integrity, the study of cultural differences indicates similarities. The dimension, act with integrity, rates as the most critical to

leadership effectiveness via importance ratings in the U.S. However, it was only considered to be critical by relative weights for one other country (Robie et al., 2000).

**Leadership Credibility and Self-Assessment**

The research of leadership credibility and self-assessment explores the significance of trustworthiness in leadership, as described in the literature. This researcher seeks to demonstrate how the self-perception of Black women's trustworthiness on the four dimensions of behavior (competence, integrity, goodwill, and transparency) may impact an individual's confidence, creativity, performance, and most importantly, opportunities for leadership advancement. Using the ITP questionnaire (see Appendix B) as a data gathering tool and as a guide for interview questions (see Appendix D), this study seeks to determine the degree to which Black women who aspire to senior management positions view themselves as trustworthy based on these four dimensions of behavior: competence, integrity, goodwill, and transparency.

Leadership has been a topic of study since the 1800s. The literature supports the need for executives to be transformational leaders (Krishnan, 2005; Kyle & Price, 2009; Riggio, 2009; Tichy & Devanna, 1986; Yang, 2016). The transformational leadership style hinges on the need for the establishment of relationships. To drive change, leaders need the buy-in of their direct reports, which requires the vital element of trustworthiness. Identifying this element is an essential leadership component, needed by African American executive leaders (Tichy & Devanna, 1986).

Individuals who ascend to executive-level leadership are influential and more transformational than transactional. Transformational leaders motivate people beyond their own self-focus with charisma, encouragement, logic, and personal thoughtfulness (Bass & Riggio,

2008). Transformational leadership is an influential leadership style that is necessary for any environment focused on meeting the needs of people.

In any industry, the real leader will have heart, skill, and sensitivity to the needs of people. Trustworthiness establishes relationships giving the transformational leader power. The leader's power comes from talent, sensitivity, and service rather than from position or force (Bolman & Deal, 2003). Power, as determined by these key factors, is what helps shape an individual's leadership style. The leadership style of a person will permeate throughout a team and will result in a forward-thinking and progressively moving organization.

There are specific requirements if an entire team is to be productive and moving forward. Individuals in leadership who are trustworthy are the beginning of this thrust forward. There should be a positive working relationship between the leader and the employees. The necessity of establishing such relationships is what drives the specifications of the required leadership traits. For this qualitative study, leadership traits are in the four behavioral dimensions of trustworthiness. If a manager is seen as competent, displays values, and supports the employees, there will be an environment of trust resulting in a highly productive work environment (Orlitzky et al., 2005).

An assessment of the self-perception of trustworthiness will be the focus of this descriptive case study. Leaders should have standard knowledge of the work and a vision with a solid belief and value system as well as self-awareness (Friedman, 2000). The examination of self will equip an individual to meet the needs of followers. Followers want credible leaders (Ambrose, 2003). Self-assessment requires examination in four categories: competence, integrity, goodwill, and transparency. The behaviors of midlevel managers may be influenced by character and self-reflection (Solomon, 2003). The self-assessment process focuses on what is

genuinely being projected by a person to others, is a true reflection of themselves. When thinking of leadership capability, the process of self-assessment can only be about one's self-perception and not the perception of others' interpretation. The outcomes may show self-assessment influences resulting in advancement opportunities.

The ITP (see Appendix B) will assess participants on the four dimensions of trust. These four dimensions are foundational for leadership and support the various leadership styles identified in the workplace. This researcher suggests that no one style of leadership is better than another. Considered to be more important are the traits that leaders display. Leaders, who display the four dimensions as identified in the ITP (see Appendix B), will lead effectively.

The four dimensions of trustworthiness align with the expectations of commendable transformational leaders. Kouzes and Posner (2003) describe the five practices of exemplary leadership as those things that leaders engage in to get extraordinary things done. According to Kouzes and Posner, "The leader should model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart" (p. 73). Being confident as leaders, specifically in the four dimensions of trustworthiness, is necessary for next-level leadership, as described by Kouzes and Posner.

**Leadership Traits and Theory**

Individuals who become superior leaders are born with certain traits that are enhanced as they grow and mature in life. These traits have existed for many years, but there has been a resurgence of assessment of such traits (Daft, 2014). Kirkpatrick and Lock, as discussed by Daft (2014), identified several personal traits that distinguish leaders from non-leaders, including some pinpointed by early leadership research. During the 19th century, the Great Man Theory, which reflects the belief that leaders are born and not made, provided essential traits that describe

a good leader (Bird, 1940). True leaders are born with certain skills and abilities that develop over time. Individuals who have such abilities that are identified at an early age will excel and become superior leaders.

An important question to answer as part of this qualitative case study is whether the study participants have a desire for leadership advancement. Participants in this current study will be screened for this vital piece of information. Studies show that the desire for advancement may not be shared, indicating midlevel managers are not a homogeneous group of people who all want to be at the higher levels (Gleeson & Knights, 2008). Self-assessment through this study will also help aspiring Black female next-level leaders to determine if there is a real desire for ascension from midlevel leadership.

There are a variety of leadership styles and perception influences those styles (Northouse, 2004). Often, exceptional leaders are perceived as transformational in their style (Riggio, 2009). Transformational leaders are refreshing, inspirational and reflect positive behaviors for an organization (Tucker & Russell, 2004). Transformational leaders drive culture change; they are visionaries that link resources and people to transform vision into realities.

Trust should be a factor for an individual to do extraordinary work as a leader. Trust requires a relationship, which is fundamentally an essential part of leadership, specifically transformational leadership. Bass, as cited by Krishnan (2005), defines a transformational leader as someone able to motivate others beyond what is expected. This thought presented by Krishnan speaks to the importance of relationship building in leadership effectiveness.

**Transformational Leadership**

Establishing relationships is a key behavioral descriptor for a transformational leader. (Northhouse, 2001; Tichy & Cohen, 1997; Tucker & Russell, 2004; Yang, 2016). Relationships

find roots in trust. Gabarro's (1978) study of how managers established relationships in the workplace, reveals that trust is a factor. Trustworthiness is an output of trust. Trustworthiness inspires trust; while trust is the result of a leader being trustworthy (Caldwell & Hayes, 2007). The interchange of trust leads to a dynamic work relationship where great leaders have great followers.

The relationships transformation leaders establish with followers elevates activity and increases the development of new leaders (Krishnan, 2005). The working relationship will require transparency, which is one of the needed dimensions of credibility. If a trait such as transparency is missing yet identified by the ITP questionnaire (see Appendix B), organizations can then offer training programs to support leadership development. Bass, as cited by Tucker and Russell (2004), conclude that transformational leadership could be learned, and it can—and should—be the subject of management training and development.

Transformational leaders encourage others to higher levels of morale and energy (Wenig, 2004). The ability to move people requires an individual to have confidence in their ability to lead at this higher level. Yukl (1989) theorizes that transformational leadership is the process of influencing significant changes in the attitudes and assumptions of the organization's mission or objectives. Transformational leadership takes self-confidence to influence others. This researcher intends to show if the lack of confidence needed for successful leadership is a limiting factor for Black women attaining executive health care administrative roles.

The impact of being a transformational leader who influences and inspires will be reflected in team members and throughout the organization. DePree (1989) states leadership measures are not just cognitive but also physical. There will be visible results for a team and the organization as a result of the work of the leader. This interaction between leaders and followers

promotes trust in the workplace supporting positive organizational change and impact. Individuals seeking leadership will need a clear picture of what they must possess for success in a decision-making role that has influence and impact on others based on the establishment of trust.

Leaders focus on meeting the needs of people while managing for organizational results. In order to drive change, execute strategy, and achieve business goals, the transformational leaders build solid relationships that reflect mutual trust. Transformational leaders provide new guidance, motivation, and expected behaviors (Tucker & Russell, 2004). African Americans, specifically Black women, can effectively operate as transformational leaders in executive health care leadership roles based on core leadership capabilities possessed just like any other leader. This current study will help identify the barriers that may hinder the opportunity to demonstrate the expected skills in senior-level leadership roles.

Transformational leadership reflects the ability to drive significant change (Daft, 2014). Transformational leadership assumes that leaders can inspire followers (Bass & Riggio, 2008; Daft, 2014). Inspiration through innovation generated by the leader or encouragement of innovative ideas from the followers is an integral part of transformational leadership. It is essential in health care leadership to meet the needs of the diverse patient population. Innovation through transformational leadership encourages contributions that strengthen the organization (Dundon & Pattakos, 2001). Tucker and Russell (2004), indicates that transformational leadership reflects innovation and differs from transactional leadership, which focuses more on policy and planning.

Wenig (2004) shows that transformational leadership creates an environment of high morale and motivation that attracts individuals to work for an organization. A transformational

leader is a style of leadership that reflects how the leader can have impact and influence (Wenig, 2004; Yang, 2016). The study of Black females' self-assessment in health care leadership may have an impact and influence on patient outcomes, which would be a true reflection of transformational leadership (Gathers, 2003; Grant, 2010; Yang, 2016).

Transformational leadership is an influential leadership style that is necessary for any environment and may drive the powerful spirit and tenor of hope (Wenig, 2004) in health care for minority populations. Whatever industry, the true leader will have heart, skill, and sensitivity to the needs of the people giving the transformational leader real influential power. The leader's power comes from the knowledge, skills, and ability they bring rather than position or force (Bolman & Deal, 2003). Understanding and applying these various aspects of leadership combined with self-assessment of credibility will make the excellent leader an exceptional leader.

**Black Women in Health Care Administrative Leadership**

African Americans, which includes Black women, along with other minority groups make up less than 1% of health care executives ("Diversity & Disparities," 2012; Lofton, 2007; Pace, 2018; Rich, 2013; Seipel, 2018). Although this percentage is significantly lower than would be expected in comparison to data that shows minority groups comprise 30% of the total population, there seems to be a desire among health care organizations to diversify more at the executive levels (Jessamy, 2000; Lofton, 2007).

Black women reflect even lower percentages in senior-level leadership (Seipel, 2018). A study of African American female graduates of Harvard Business School reflects out of two-thousand three hundred graduates since the school's inception in 1908, only sixty-seven have reached the Board Chair, CEO or other C-Suite level executive positions in corporate America

(Roberts et al., 2018). An even more alarming statistic reflects the continued gender discrimination, pay inequity, topped by the racism faced by Black women in the workplace; reflecting compounded institutional barriers that block opportunity for advancement (Dickens & Chavez, 2018; Livinston, 2018; Pace, 2018; Seipel, 2018).

A significant number of African American workers, inclusive of Black females, are among the staff of health care organizations across the country; however, the same is not true of executive leadership in those same organizations ("Diversity & Disparities," 2012; Gathers, 2003; Rich, 2013; Seipel, 2018; U.S. Department of Health and Human Services, 2017). Female and minority instructors and learners are acutely underrepresented in academic health care organizations (Kosoko-Lasaki et al., 2006; Thew, 2019). Limited data is available that explicitly discusses Black women as leaders in health care; however, the available data does support the reality that there is a lack of Black women represented in health care leadership (Gathers, 2003; Jessamy, 2000; Lofton, 2007; Pace, 2018; Seipel, 2018; Wolliston, 2008). One of the potential benefits of this study is to identify the contributions that Black women could make in the decision-making process in health care administration if afforded the opportunity, even when their lack of opportunity is self-induced.

**Black Women as Senior Transformational Leaders**

Individuals such as Dr. Ruth Simmons and General Colin Powell have been described as African American transformational leaders (Chekwa, 2001). Dr. Simmons was the first African American president of an Ivy League University, Brown University; while General Powell was the first African American Secretary of State of the United States of America (Chekwa, 2001). Both have demonstrated stable leadership traits, including trustworthiness. To attain such levels of leadership, being confident in one's own ability may have been a factor.

Many different leadership styles exist. This proposed qualitative case study will consider the transformational leadership style (Bass & Riggio, 2008; Chekwa, 2001; Friedman, 2000; Kyle & Price, 2009; Riggio, 2009). The earliest acknowledged African American transformational leaders were two individuals in the early 1900s, Booker T. Washington and W.E.B. Du Bois. Although Washington and Du Bois had opposing views on how to produce African American leaders, they both contributed significantly to the progression of African American leaders in the United States (Watson & Rosser, 2007). Early contributions of African Americans link to other great leaders such as Dr. Martin Luther King, Jr. Contributions from leaders like Dr. King provided a foundation for the first African American to be elected as the executive leader of the United States, President Barack Obama.

The acknowledgment of key African American leaders is essential to this study because it provides an example of what trustworthiness can look like for those viewed as successful Black leaders. Black women can ascend to higher levels of leadership in this country, even in health care administration. Although current numbers are small, diversity in senior-level leadership is a reality. The work that has led to the success of Black American leaders in such as Dr. King and others, should be the same expectation specifically for health care leadership. Through self-assessment, Black women in health care administration can determine if they limit their success due to self-imposed factors.

The leadership traits displayed by successful African American leaders such as President Obama and Dr. Martin Luther King should be mirrored by Black women aspiring to be in executive leadership. This study allows aspiring individuals to have self-reflection and an honest assessment of themselves. Self-assessment for leadership development and the prospect of

advancement opportunity should prove to be an invaluable process for aspiring Black female leaders.

Ambrose (2003) suggests that the transformation of an organization starts with self. Self-assessment is the starting point for establishing a trustworthy relationship between leaders and employees. Effective leaders who are viewed as trustworthy, have organizational impact and positive influence on people (Caldwell & Hayes, 2007). There needs to be a clear understanding of leadership and self-awareness in order to carry out an exceptional job as a leader. This requires self-assessment as part of the process of climbing the metaphorical career ladder even before reaching midlevel manager assignments (Thomas & Gabarro, 1999).

Executive leaders who drive change have skills and display behaviors developed during their ascension to their decision-making role (Thomas & Gabarro, 1999). Transformational individuals will know the skills they possess through self-assessment and will have the ability to drive change efforts once they move into an executive leadership role. One cannot support, share, or even understand the vision of an organization until there is adequate knowledge of self. The stages of development will happen over time and can take place even after leadership positions have been assigned. This process allows the leader to examine themselves and to cultivate needed skills.

In any organization, at the center of every great team is a great leader. Individuals in this position of influence and power will possess solid traits, including self-confidence, as will be measured by the ITP in this current study. Collins (2005) describes a good leader as one who achieves Level 5 Leadership. Level 5 leadership refers to the highest level in a hierarchy of executive capabilities, as identified by Collins. Collins argues that for companies to be successful, there should be a great high-level leader. High-level leadership means a person in

leadership should have a heart but should have the added traits that balance them out, including self-confidence in his or her ability to fill the role. Identification of Black females as transformational, great leaders with the needed confidence may be an additional result of the work of this current study.

**Diversity in Health Care Leadership**

The lack of diverse leadership is a familiar reality to hospitals and health care organizations ("Diversity and Disparities," 2012; Gauss, 2012). Throughout history, people of color have not been afforded the same opportunities for advancement in health care leadership as their Caucasian counterparts (Gauss, 2012; Jackson, 2004; Pace, 2018; Thew, 2019; Watson & Rosser, 2007). The general approach to the shortage of health care workers in the past focused on increasing education in health care specialties and administration for people of color; however, recruitment into higher levels of leadership still reflects low numbers ("Diversity and Disparities," 2012; Sullivan, 2004).

The Sullivan Commission on Diversity in the Healthcare Workforce (2004), reviews reasons for the lack of diverse leadership and identifies that causes for the disparity are not multi-faceted but include the single factor of racial and ethnic inequality. There have been limited leadership opportunities in the health care industry due to historical segregation in the United States (Sullivan, 2004; Watson & Rosser, 2007). Healthcare education, including schools of medicine, dentistry, and nursing historically have been last on the list to integrate their learning environments (Bland, 2019; McGee Banks, 2000; Sullivan, 2004; Thew, 2019; Yancey, 2018). The current make-up of racial and ethnic minorities in health care roles such as physicians and nurses include less than 10% African American, Hispanic, and American Indian, others ("Diversity and Disparities," 2012; Sullivan, 2004).

The increased interest of the public, coupled with concerns for the future of health care in ethnic America, has increased the monitoring and research in the area of the disparity in health care services and health care leadership (Rosenberg, 2008; Sullivan, 2004). Many health care organizations have attempted to become involved in the identification of solutions by implementing diversity programs to include Chief Diversity Officers, Employee Resource Groups, targeted health care forums among a host of other initiatives (Clapp, 2010).

## Conclusion

Trustworthiness is a cornerstone of leadership. Through self-assessment, Black females are able to identify the self-imposed factors that may be hindering them from being trustworthy transformational leaders in health care administration. The lack of literature supports the need for this study given there is a lack of Black female representation in senior leadership positions in health care possibly due to a self-perceived lack of credibility. In order to develop as a leader and be considered credible or trustworthy enough for senior leadership positions, individuals must engage in self-reflection aimed at personal mastery in the areas of competence, integrity, goodwill, and transparency (Ambrose, 2003).

Chapter 2 presented information on Black women in health care leadership, credibility, credibility of Black women, transformational leadership, health care leadership, and leader self-assessment. The research supports the fact that there are few African Americans, inclusive of Black female, in leadership in the health care industry. There is little data to support self-perception as the reason, however, the outcomes of this study may result in robust reportable data regarding perception of trustworthiness as a needed leadership trait for Black women in health care leadership. The approach to data collection and the details of the research methodology and design for this current leadership study is detailed in Chapter 3.

# Chapter 3

## Methodology

Chapter 3 outlines the research methodology and design of the planned qualitative descriptive case study. Elements of the research design found in Chapter 3 include the population, geographic location, informed consent forms, confidentiality, research questions, and hypotheses. Chapter 3 includes detailed sampling information, data collection, and data analysis. Chapter 3 ends with a justification for the research design compared to alternative designs.

Self-awareness and self-confidence are essential aspects of successful leadership. This qualitative descriptive case study explored Black women's self-imposed barriers to leadership advancement using the four dimensions of trust: competence, integrity, goodwill, and transparency. There may be self-imposed obstructions that limit opportunities for the attainment of senior administrative leadership positions as a result of this study. This study may lead to possible recommendations for overcoming such obstacles in future studies. The outcomes provide for study participants and other Black women opportunities for self-awareness and self-confidence to a demographic of people not readily seen in senior leadership roles in health care administration.

### Research Method and Design

The chosen research methodology and design of a descriptive case study are best for the collection of data focusing on factors that will contribute to understanding the self-imposed limitations that may exist for Black females in health care administration who aspire to be senior administrative leaders (Adams & Lawrence, 2019). The descriptive case study method for this study focused on trustworthiness exploring the self-perception and experiences of Black female health care midlevel managers. The Black female midlevel health care professionals were in the

northeastern United States, specifically in and around Boston, Massachusetts. This qualitative study is a descriptive case study that used the ITP (see Appendix B) and semistructured interview questions (see Appendix D) to explore the perceptions and experiences of Black females in health care leadership.

A qualitative case study is a research design that investigates the details of a situation or case in comparison to a specific situation (Yin, 2013). A qualitative descriptive case study design will support the review and exploration of the identified Black female professionals' self-perceptions of trustworthiness as it relates to preparedness for leadership opportunities (Adams & Lawrence, 2019). This study combined a narrative analysis of semistructured interviews and questionnaire responses outlining the collective perspectives of the participants' thoughts, ideas, experiences (Adams & Lawrence, 2019; Neuman, 2003). The data collection approach expects to yield quantitative data as a result of the perspectives of the study participants (Adams & Lawrence, 2019). Data that could help with the identification of self-imposed barriers will be gathered from the use of a questionnaire and semistructured interview in this current qualitative descriptive case study.

A questionnaire is an instrument commonly used for data collection in business research (Cooper & Schindler, 2008). Questionnaires are often used to consider diverse theories (Adams & Lawrence, 2019). The use of a questionnaire allows for data collection using inquiries centered around a theme often in the form of a Likert-type scale (Adams & Lawrence, 2019).

The use of interviews is common for data collection in qualitative research studies (Cooper & Schindler, 2008). For this approach to be successful, the interviewer should be a trained interview or have significant experience in interviewing (Cooper & Schindler, 2008). In qualitative research leveraging interviews ensuring understanding and gaining insight is

foundational, and they can be structured, unstructured, or semistructured (Adams & Lawrence, 2019; Cooper & Schindler, 2008). The semistructured interview for this current study allows for a structured set of questions along with follow-up questions for additional clarification (Adams & Lawrence, 2019).

This design of this study was to identify the perspectives of Black female participants who aspire to be in a higher level of leadership in a health care organization. This study reflects data collection using the ITP (see Appendix B) along with semistructured interview questions (see Appendix D). The data collection took place in a sequential approach. Participants were asked to first complete the self-assessment tool, the ITP questionnaire (see Appendix B). The self-assessment tool showed how participants view themselves on the four-dimensional scale for trustworthiness. The purpose was to determine whether there are different themes regarding trustworthiness and each individual's identification of their ability for advancement in health care leadership. The exploration of thoughts, ideas, and lived experiences through semistructured interviews of the aspiring Black females provides meaningful information for the assessment of possible barriers to their leadership advancement as Black women. The stories detailing their lived experiences provides essential data to understand better the specific limitations that Black women may have placed on themselves, limiting their opportunities for advancement.

After completing the self-assessment questionnaire, additional information was gathered through semistructured interviews (see Appendix D). The semistructured interviews concentrated on questions related to the needed dimensions of trustworthiness for advancement in leadership with follow-up questions to gather more information (Adams & Lawrence, 2019). The interviewees were the same Black females from midlevel management or higher in health care administration who have completed the self-assessment. A practical method for collecting data is

the use of a live recording of interviews asking open-ended questions (Yin, 2013). Yin (2013) suggests that this method of data collection provides an opportunity for accuracy when obtaining the thoughts and feelings of participants.

## Appropriateness of Research Design

The descriptive study design selected for this study was appropriate for capturing individuals' perspectives about self and the impact it may have on their future state (Adams & Lawrence, 2019). Yin (2013) describes research design as a sound map for moving from one point to another, where the original point may be a set of questions that requires responses. The self-perceptions of the participants in this study was the focus of the data collection, which is supported using a descriptive study to provide insight into behavior, attitude, characteristics or conditions (Adams & Lawrence, 2019). This study reflects two measurement methods, questionnaire and semistructured interviews combined to explore a specific phenomenon in a specific population (Adams & Lawrence, 2019).

Qualitative research is nonprobability sampling, reflecting minimal effort to generate a representative sample (Cooper & Schindler, 2008). The way data are collected for this current research, along with the purpose of the study, and the demographics of the target population, all combine to indicate a smaller sample size is most appropriate. The number of initial participants for this study will be limited to 20 Black females in health care administrative midlevel managers or higher, who aspire executive leadership in health care; however, using the snowballing approach may yield a larger sample.

Leedy and Ormrod (2001) indicate that qualitative researchers know their chosen study is multi-layered and has several dimensions. In a qualitative study, information is reviewed over a period observing details that demonstrate a particular theme (Adams & Lawrence, 2019;

Creswell, 2002, 2013; Leedy & Ormrod, 2001; Neuman, 2003; Yin, 2013). Patton (1990) indicates that qualitative methods result in a large amount of detail for a smaller group and situations. The use of the ITP questionnaire (see Appendix B) for this study reflects the nonnumerical measures of a qualitative approach, which will yield specific results (Adams & Lawrence, 2019). This data combined with the output from the semistructured interviews for the generation of overall study results.

As described by Creswell (2002), in qualitative studies, the researcher relies on the views of participants, asks broad, general questions, collects data from participants, describes and analyzes these words for themes, and conducts the inquiry in a subjective, biased manner. A qualitative approach serves the need for exploration of personal experiences (Adams & Lawrence, 2019). A qualitative approach uses an exploratory tool to interpret humanistic perspectives and experiences (Marshall & Rossman, 2011).

This qualitative descriptive case study combined an analysis of questionnaire responses and a narrative analysis of semistructured interviews focusing on Black females' self-perception of trustworthiness, and how that hinders or supports advancement to leadership positions in health care organizations. This study used a nonrandom selection process, and the data collection will be sequential. The initial group of study participants were asked to participate with additional individuals invited to participate by original contributors.

## Data Analysis

An analysis was conducted to yield information as provided by the participants. The ITP instrument (see Appendix B) allowed for varying responses that have been categorized according to the preset dimensions of competence, integrity, goodwill, transparency. The self-perception of the trustworthiness of Black women health care workers are clear and measurable, allowing for

firm data using a questionnaire (Cooper & Schindler, 2008). The second phase of the data collection process allowed for detailed responses to set interview questions (see Appendix D) along with follow-up questions to gather additional data or to clarify information (Adams & Lawrence, 2019). This second method for data collection allowed for subjective data through open dialogue using a consistent set of interview questions and follow-up (Adams & Lawrence, 2019). This data can then be collected and categorized based on common themes (Creswell, 2004). This two-phased approach to gather and analyze data was the best approach based on the needed data for this study. This study intended to obtain detailed information from a small sample of Black women who work in health care within a specific geographic location.

## Research Questions

The purpose of this qualitative descriptive case study was to identify self-imposed barriers of Black women's opportunities to attain executive administrative leadership positions and provide recommendations for overcoming such obstacles. The following research questions guided this study:

**RQ1.** What is the self-perceived level of trustworthiness of Black women who desire to obtain higher levels of administrative leadership as measured by the four dimensions of trustworthiness: competency, integrity, goodwill, and transparency? The Black female participants of the study may indicate they see a lack of trustworthiness based on how they view themselves across the four dimensions. This study seeks to understand if this self-perception results in self-doubt, which in turn leads to stagnation in advancement opportunities.

**RQ2.** How does the perception of trustworthiness influence self-doubt and the potential for leadership advancement for Black women in health care administration? By hearing firsthand from African Americans who are prepared and desire to be in higher levels of health care

administrative leadership, as well as those currently in such roles, there will be robust data available for future studies. Past studies have focused on what leadership in organizations can do to be more inclusive (Pace, 2018; Thomas & Gabarro, 1999). This study will focus on self-reflection to assess if such internal views influence the suggested glass ceiling (Hyun, 2005) that limits opportunity.

**RQ3.** How might these issues be addressed as described by current Black female leaders based on their experience in their role and how they viewed themselves through the lens of the four dimensions of trust? As the study of leadership continues to evolve, understanding the perspective of minority leaders may provide insight into the limitations that block their advancement. The perspective of the Black female leaders identified for this research can lend insight that may add significant value to the study of leadership for Black people and other minority groups.

## Population

Population, as defined by Creswell (2002), a group of individuals who have different characteristics than other groups. The participants of this study are 20 Black female managers in health care organizations. The U.S. Bureau of Labor Statistics (2009) lists Boston as one of the 12 largest cities in the country, with over 480,000 people employed in education and health care. The individuals identified for this study were professionals from administrative areas of health care in Boston, Massachusetts, and its surrounding communities. A nonrandom snowball method of sampling was used to collect the needed data.

This current research was conducted using purposeful sampling to identify Black female midlevel managers in health care organizations. There are over 20 hospitals in Boston, Massachusetts; however, this study will select participants from only a sampling of such health

care organizations. This study identified participants who are current, or past employees in two or more Boston hospitals ranked in the top 20 hospitals in the United States ("2019–20 Best Hospitals," 2019). The annual Best Hospitals report of rankings in the United States hospitals based on their performance in complex specialty care, procedures, and conditions ("2019–20 Best Hospitals," 2019). This identification of specific hospitals was not to assess the hospitals in any way. The focus of the study was the lived experience of the identified Black female participants. With the selection of possible participants being small, and the snowball method resulted in Black female participants from other health care organizations in the Boston area, they were invited to participate in the study as well.

## Sampling

The use of snowball sampling allows participants to recruit additional participants for study (Adams & Lawrence, 2019). The sample size is essential, and various factors dictate (Cooper & Schindler, 2008). This researcher plans to limit study participants to 20; however, given the use of snowball sampling, the number of participants above 20 may result. Creswell (2002) states there is a lower probability of error with a larger sample in qualitative research. It is suggested that as large a sample as possible be chosen from the populace (Creswell, 2002). Berg (2009) suggests the sample is large enough to ensure clarity on why a particular occurrence took place. For this study, given the target population, the sample size was smaller than recommended.

The use of the nonprobability sampling strategy of snowballing allowed for leveraging of the informal connections within the Black community. Cooper and Schindler (2008) states several factors influence sample size, including dispersion or variance within the population and the number subgroups the researcher identifies within the sample. The sample should not be too

small so that there is limited data to support the theory, nor should the sample be too large that it limits the in-depth analysis needed for quantitative research (Cooper & Schindler, 2008). As it relates to transferability, Creswell (2013) indicates that having a larger sample might be advantageous as it would allow more significant movement of data to other frameworks. For this current study, research expectations, as described, are more challenging to meet, given the limited number of Black female health care leaders (Thew, 2019).

A target percentage should not be determined for sample size (Cooper & Schindler, 2008). It is believed that 10% of any size and kind of sampling population is appropriate; however, Chisnall (1986) indicates this may not be accurate. The goal of the researcher should be to base their sample size on an acceptable margin of error (Cooper & Schindler, 2008). Determining an adequate sample size will require much judgment on the part of a quantitative researcher (Cooper & Schindler, 2008). For this current study given the use of a survey, the identified sample size was limited to 20, given the limited number of Black females in health care administrative management (Pace, 2018; Thew, 2019). Also, the study was limited to the specific geographical area, Boston, Massachusetts, which required a more focused number of study participants from specific organizations.

Data were collected using the ITP (see Appendix B) combined with semistructured interviews (see Appendix D). Initial participants for this current study were identified as holding midlevel management positions in their organization being initially selected through the professional networks of this researcher within health care human resources combined with the nonprobability sampling strategy of snowball sampling (Adams & Lawrence, 2019). E-mail addresses were obtained from the social network websites LinkedIn for the initial invitation to participate in the study.

During the opening minutes of the interview, the researcher discussed with study participants their needed consent, the questionnaire, interview process, and an overall review of the study. Participants were asked to sign the Participant Consent Form (see Appendix A) and a copy was provided to them.

E-mails were sent to participants inviting them to participate in the study. The invitation included the informed consent and the ITP questionnaire (see Appendix B) accessible through a link to an online survey platform. The e-mail detailed how to complete and submit the questionnaire along with options for scheduling their interview. Interviews were conducted video using the online platform Zoom. Given the current state in American, the COVID-19 Pandemic, an online meeting platform was the best alternative. Face to face is the preferred option as it allows opportunity for observation and documentation of nonverbal as well as verbal behaviors (Cooper & Schindler, 2008).

## Data Collection

The results of the data collected from the ITP (see Appendix B) and responses to semistructured interview questions (see Appendix D) have been analyzed and compiled based on themes that emerged. This current descriptive case study includes interaction with participants using a questionnaire and an interview. There are several methods of data collection when using case study research, including interviews, observation, documents, and questionnaires (Adams & Lawrence, 2019; Creswell, 2013). The questions used in a case study focuses on specific events or situations and how they relate (Adams & Lawrence, 2019; Soy, 1997). Because case study research produces lots of data from a variety of sources, it could generate a large amount of information to review (Cooper & Schindler, 2008; Soy, 1997). The case study approach requires

exceptional organization skills to ensure the researcher has clarity, which keeps them from being overcome by the massive amount of data (Soy, 1997).

To avoid information overload, Soy (1997) recommends that the researcher establishes a system for organizing the data to avoid losing focus on the original purpose of the study. A case study is also a research strategy that focuses on examining a current phenomenon and other ideas associated with the phenomenon (Adams & Lawrence, 2018; Dooley, 2002). This qualitative descriptive case study combined a narrative analysis of interview responses with a content analysis of questionnaire responses. The questionnaire responses were supplemented by interview questions designed to further probe respondents' view of the degree to which they exhibit the behaviors and attitudes associated with trustworthiness: competence, integrity, goodwill, and transparency. If Black women in the study were in senior leadership roles, the researcher included them in the study for an additional perspective on the self-perception of trustworthiness as a vital factor for leadership advancement.

The ITP questionnaire, as outlined in Appendix A, was imported into an online survey tool for distribution to study participants. Survey Lab, the tool used, is an online survey tool used by thousands of individuals and companies to collect information for various reasons. The survey link was sent to participants via e-mail. Once the data were collected through the online survey tool, open-ended questions were formulated, then interviews (see Appendix D) scheduled. The open-ended questions were created based on the data collected from participants using the ITP (see Appendix B).

This study is a qualitative descriptive case study that combines a narrative analysis of interviews with a content analysis of questionnaire responses. Self-assessment was used to obtain data on how the participants view themselves as leaders. Open-ended interview questions (see

Appendix D) were used to gather details of the participants' past experiences providing insight into how their view of self contributes to their opportunities for career progression.

The Trustworthiness Behavioral Interview questions (see Appendix D) also focused on the perception of trustworthiness, allowing for elaboration on aggregated questionnaire responses. The self-assessment questionnaire, the ITP (see Appendix B). The interview questions were open-ended, focusing on the lived experiences of study participants. Interviews can be beneficial to any study, particularly case study (Cooper & Schindler, 2008). There are disadvantages of using interviews, including interviewer bias and inaccuracies in the coding of the interview data (Adams & Lawrence, 2019; Yin, 2013). It is the opinion of this researcher the advantages outweighed the disadvantages that presented with data collection through semistructured interviews. This approach allowed individuals to tell their stories and experience in a very detailed way. An interview offered a form of dialogue between the researcher and the study participant using a question and response format to collect data (Hesse-Biber & Leavy, 2011). Collecting data in this way is common with qualitative research (Adams & Lawrence, 2019; Cooper & Schindler, 2008).

Theory may or may not be generated by qualitative interviews when used to gather exploratory or descriptive data (Hesse-Biber & Leavy, 2011). When a study focuses on concerns, and there is a need for detailed information from an individual's perspective, a survey through the use of in-depth interviews would be the approach (Adams & Lawrence, 2019; Hesse-Biber & Leavy, 2011). This approach gives the opportunity for researchers to get clear, detailed information from interviewees requiring them to write out detailed notes to apprehend the core of the topic (Creswell, 2013). Interviewing was a useful approach with this current narrative study as the personal experiences of individual study participants are vital to the outcomes of the study.

## Informed Consent and Confidentiality

The fair treatment and rights of participants will be considered. The informed consent of individual subjects was obtained using the informed consent form, as displayed in Appendix A. The data was summative, and any information on the human subjects was blinded. Written consent was obtained from the participants to allow permission to utilize the data in an anonymous format (see Appendix A). This form was provided to the participants via a link in the e-mailed invitation. along with the ITP questionnaire (see Appendix B). The informed consent and ITP were both made available using the online tool, Survey Lab.

The names of each participant and their respective organizations remain confidential and blinded to the reader. All data is used in aggregate form, and the researcher does not have access to any of the identifying data for the participants in the study. There is no potential to access personal information from the data, as presented in this format. The ITP questionnaire (see Appendix B) was set using an online survey platform, Survey Lab. This resource provided a confidentiality statement that is appropriate for this study. The data collected for this study has been stored and will be maintained for three years then destroyed using a shredding method.

For this qualitative descriptive case study, to also maintain participant anonymity, a unique identifier was created and assigned to each participant (Neuman, 2003). The identifier was used for all participants during data collection and data analysis. There was no additional coding used for participants.

## Geographic Location

This case study was conducted in Boston, Massachusetts, in the northeastern United States. The participants included 20 Black female administrative professionals of health care organizations. The individuals were all Black females employed by a health care organization.

The identified group were midlevel managers and above in health care administrative leadership. There also were some professional-level employees who desire to advance to executive-level leadership.

In the Boston, Massachusetts area, there are over 50 health care organizations with several being world-renowned academic medical centers. This number reflects a variety of health care organizations, including academic medical centers and community health care centers. This study will initially identify participants who are current, or past employees in two Boston hospitals ranked in the top 10 hospitals in the United States ("2019–20 Best Hospitals," 2019). The annual Best Hospitals report of rankings in the United States hospitals based on their performance in complex specialty care, procedures, and conditions ("2019–20 Best Hospitals," 2019). To ensure a sufficient sample of 20 or more, the Black female participants may also be from any of the fifty-plus health care organizations in the Boston, Massachusetts, area if specifically recommended through snowball sampling.

## Instrument

It is important that any instrument used in a study be tested for validity to ensure that it can accurately test or measure what is intended. According to Creswell (2013), a valid instrument ensures that the variation in results from the test group is an accurate reflection of the group. The ITP (see Appendix B), the questionnaire for this study, has been validated from a database of 200 corporate respondents who have used the ITP in management training seminars between 1998 and 2008. Additional data since 2008 is not available to this researcher due to the 2009 death of the questionnaire owner, Dr. Delorese Ambrose. Dr. Ambrose provided written approval for the use of the instrument before her death (see Appendix C).

The ITP is a 32-question inquiry form designed for self-assessment of one's leadership behaviors. This instrument is based on research that formed the foundation for understanding the internal personal mechanics of a leader (Ambrose, 2003). Ambrose (2009) indicates that the ITP is designed to measure trustworthiness as it relates to identifiable behaviors. There are two versions of the tool, self, and teams; however, for this study, the ITP self-version is being used. This version allows participants to assess their behaviors based on how they relate to others. The ITP questionnaire for use in this current study of the credibility of Black females in health care leadership, leverages a Likert-type scale with four response options of 1 (NOT descriptive of me) to 4 (VERY descriptive of me). The ITP questionnaire provides a list of 32 statements, and participants were asked to rate themselves by writing (1, 2, 3, or 4) in the circle to the right of each statement. The circles are placed in one of four columns labeled A, B, C, D. The four letters are aligned to the four dimensions of trust: competence, integrity, goodwill, and transparency (Ambrose, 1998). The participants completed a multiple-choice version of the ITP online. The data were transferred to the MS Word version of the tool for distribution to participants as PDF file.

The follow-up to the completion of the questionnaire was a 45-minute interview with specific open-ended questions (see Appendix D) aligned to the four categories of trustworthiness from the ITP (see Appendix B). There were ten questions with one or two follow-up questions as needed to gather additional insight. The same questions were asked of all study participants.

## Reliability

Reliability refers to the repeatability of the results (Creswell, 2002). The reliability of the data reflects the consistency of the occurrence of the results and whether future researchers would potentially reach the same conclusion (Adams & Lawrence, 2019). Current studies were

underway before the death of Dr. Ambrose to test the reliability of the ITP tool. Additional data on the status of those studies are not available to this researcher. Given the nature of this current study, the researcher researched with the tool in its current genesis.

## Validity – Internal and External

Creswell (2013) posits that validity reflects the connection of the results to the participants, accuracy, and strength of the researcher's findings from various views (Creswell, 2013; Warren & Karner, 2005). Validity refers to the appropriateness of the research concerning the research question (Adams & Lawrence, 2019; Creswell, 2002). There are eight validity strategies as described by Creswell (2002): (a) triangulate different sources of information; (b) use member-checking to determine the accuracy of the qualitative findings; (c) use detailed, thick description to convey findings; (d) clarify the bias the researcher brings to the study(e) present the negative or discrepant information that runs counter to the themes; (f) spend prolonged time in the field; (g) use peer debriefing to enhance the accuracy of the account; and (h) use an external auditor to review the entire project.

### Internal

According to Creswell (2002), internal validity refers to "experimental procedures, treatments, or experiences of participants that threaten the researcher's ability to draw correct inferences from the data in an experiment" (p. 171). For this qualitative study, the experiences of incumbent executive leaders may have presented a challenge with much of their responses focusing on their personal experience resulting in interview bias. Validity threats were mitigated by asking open-ended questions during the interviews.

**External**

External validity is the ability to generalize the findings of a specific study (Adams & Lawrence, 2019; Cooper & Schindler, 2008; Neuman, 2003). The results of this current study provided information that could be transferable to other studies of Black leaders in the United States to determine how closely the information matches in other subpopulations in the African American community (Adams & Lawrence, 2019; Merriam, 2002). The outcomes of this study may apply to other studies such as (a) African Americans leadership; (b) Black men in leadership; (c) Alternate solutions for the lack of equality in executive leadership. By understanding the issues identified in this current study, health care organization leaders may use the findings as a point of reference to guide African Americans and other minority groups to executive leadership positions.

## Data Analysis

According to Cooper & Schindler (2008), the significant entry to the process of inquiry, is learning the key issues within an organization then identifying the core believes and patterns behind those issues. The discovery of the critical issues happens during the data analysis process. The researcher tabulated the data gathered from the ITP (see Appendix B) responses and the interview questions (see Appendix D) to identify and document the areas of which Black female leaders scored themselves lowest on the trustworthiness scale. The ratings from the questionnaire, as well as their described areas of concern presented during the interviews, were synthesized as output. This researcher identified themes that may be converted to areas of opportunity for individual development for Black women in health care leadership. The development of skills in the identified area may positively impact their ability to secure senior leadership positions. A goal was for participants to self-identify patterns of behavior through

responses to a questionnaire and interview questions, with the results possibly showing their trust scores contrast with what is expected of a senior level leader.

## Chapter Summary

This study was a qualitative descriptive case study focused on the experiences of Black female administrative health care leaders. The purpose of this qualitative descriptive case study was to explore the perceptions of Black female leaders on trustworthiness using a self-assessment instrument combined with an interview. The study was designed to evaluate the self-perception of leadership credibility using the four dimensions of trustworthiness. Chapter 3 outlined this study's research methodology, design, and supporting aspects of the approach. Upon completion of the study, data from participants will be collected and evaluated. The collected data provides new information on the self-perception of trustworthiness as defined by the four dimensions of trust.

The data collected using the ITP (see Appendix B) and semistructured interview questions (see Appendix D) provides the foundational information for analysis and recommendations. Chapter 4 provides and analyzes the research study's data collected by implementing the research methods presented in chapter 3.

# Chapter 4

## Analysis and Results

The purpose of this qualitative descriptive case study was to identify self-imposed barriers of Black women's opportunities to attain executive administrative leadership positions and provide recommendations for overcoming such obstacles. The study participants assessed their self-perception as Black women in health care administration as measured by the four dimensions of trustworthiness which are competence, integrity, goodwill, and transparency. Chapter 4 includes the steps used for data collection and analysis, as well as the study findings presented in categories based on themes. The conclusion and summary are presented at the end of Chapter 4.

### Research Questions

This qualitative descriptive case study focused on the self-imposed barriers resulting from the lived experiences of Black women in health care administration. The following research questions guided the study:

**RQ1.** What is the self-perceived level of trustworthiness of Black women who desire to obtain higher levels of administrative leadership as measured by the four dimensions of trustworthiness: competency, integrity, goodwill, and transparency?

**RQ2.** How does the perception of trustworthiness influence self-doubt and the potential for leadership advancement for Black women in health care administration?

**RQ3.** How might these issues be addressed as described by current Black female leaders based on their experience in their role and how they viewed themselves through the lens of the four dimensions of trust?

## Data Collection

This study is a qualitative descriptive case study that combines a narrative analysis of interviews with a content analysis of questionnaire responses. Self-assessment was used to obtain data on how the participants view themselves as leaders. Open-ended interview questions (see Appendix D) were used to gather details of the participants' past experiences providing insight into how their view of self contributes to their opportunities for career progression.

Data in this research study were collected in two phases. The data collection tools were a questionnaire and interviews. Participants completed a short questionnaire and had an interview with the research. The questionnaire used was IPT available through the online survey platform, Survey Lab. Participants were assigned a number to ensure confidentiality using the numbers 1 through 20.

### Phase 1: Questionnaire

Participants in this research study were Black female midlevel managers in health care organizations. A recruitment e-mail (see Appendix E) was sent soliciting participants who were interested in participating in the study. The women who received the e-mail were provided with instructions in the e-mail on how to access and complete the informed consent and the ITP for Phase I of the study. They were also provided with a link to schedule the follow-up interview with the researcher as well.

In Phase I, 35 women were invited to participant in the study. They were identified using the snowball method and only 20, responded and all 20 complete the questionnaire. The first 4 identified study participants completed the questionnaire within a few days of receiving the invitation with subsequent participants taking 2 to 3 weeks to respond. The researcher sent follow-up e-mails to remind participants about participation in the study. The responses were

slow with all questionnaires being completed over a five-week period. Study participants were informed the completion of the questionnaire would take approximately 15 minutes. The average time for completion of the questionnaire by participants was 10 minutes. The online survey platform used for the questionnaire was Survey Lab.

Upon completion of the questionnaire, the researcher transferred the data from the online questionnaire tool, Survey Lab to a MS Word version of the ITP assessment. The scores for each of the four dimensions of trustworthiness we totaled and the results along with descriptors was provided to each person as a PDF file prior to conducting their interview with the researcher.

**Phase 2: Interview**

Interview questions were formulated prior to the launch of the questionnaire and reflected questions aligned to the same four dimensions of trust from the ITP. The questions were designed to obtain additional data that described the participants' lived experiences as Black women in health care administration. The questions were structured and asked of participants consistently to gather responses allowing for greater exploration of the subject. An interview guide was used to ensure consistency (see Appendix D). The online platform Zoom was used to conduct and record the interviews.

The researcher reviewed a brief opening using the established interview guide followed by a review of participants ITP results before moving to asking the prepared interview questions. Participants were informed the interview as being recorded. Each question was asked as written in the interview guide with appropriate follow-up questions for clarification when needed. Each interview was scheduled for 45-minutes each using the scheduling tool Calendly allowing participants to select the time that worked best for them. Each interview latest 30-45 minutes

each. Each participant appeared calm and fully engaged in interview and openly shared their personal experiences and perspectives.

## Demographics

Participants in this research study were Black female midlevel managers in health care organizations. This study only included women who classify their ethnicity as Black women which included, self-descriptors including woman of color, African American, Black, Latino, Asian America. There are no aspects of this study that focused on colorizing race, meaning light skinned, dark skinned, et cetera. Participants were Black women over the age of 21 years, currently or were previously employed in a health care administrative role as a mid to senior level manager and hold a minimum of a bachelor's degree or 5 years of leadership in a health care organization. Some study participants did not hold leadership positions but aspired to be in senior-level leadership.

## Data Analysis

### Phase 1: Questionnaire

Data were transferred from the online tool, Survey Lab to MS Word. Participants were assigned numbers 1 through 20 with the same number being later assigned to their interview data. The questionnaire provided the core foundation of the study; however, the greater focus was on the data gathered during the interviews which focused on the lived experiences behind the data from the ITP. The four dimensions of trustworthiness, the descriptors, self-ratings and rating by category provided reference points for participants during their interview.

The ITP has 32 questions with each fitting into one of the four dimensions of competence, integrity, goodwill, and transparency. Participants ratings were very similar for most participants with the dimension of transparency, which consistently shows the lowest

ratings. To get the rating for each dimension, questions aligned to each, were manually tallied by the researcher, with each dimension having a highest rating of 32. This instrument is designed to measure trustworthiness as it relates to identifiable behaviors. Participants assess their behaviors based on how they relate to others. The ITP questionnaire leveraged a Likert-type scale with four response options of 1 (NOT descriptive of me) to 4 (VERY descriptive of me).

The ITP questionnaire provided a list of 32 statements, and participants were asked to rate themselves by choosing aa number, 1, 2, 3, or 4, with the number one being least like them and the number four being most like them. Each question was assigned a letter which corresponded to the four dimensions. The data were transferred to the MS Word version of the tool for distribution to participants as a PDF file. The data were analyzed based on the Likert-type scale associated with the tool.

The highest possible score for each category was 32. The higher the score the more a person views themself as trustworthy in each dimension. This data gathered through the interviews enhanced and validated the study findings specific to the self-imposed limitations placed on Black women in health care administration.

The four dimensions of trust as defined by the ITP also provided the foundational approach for the interview questions. For the purpose of this study, competence is being reliable--embracing learning opportunities and consistently getting good results. Competence includes problem-solving and decision-making skills, an ability to implement effective changes, technical know-how, as well as the interpersonal or leadership skills needed to consistently achieve performance goals and objectives with and through others. Integrity is being honest, keeping promises and taking actions that match stated values and beliefs. Integrity literally means "wholeness." Goodwill is caring about others and showing it. This dimension of trust, also

labeled “benevolence,” is a critical, but often overlooked, link to personal effectiveness. We demonstrate goodwill when we treat people as they would like to be treated. Transparency is communicating openly and disclosing true feelings. Because self-disclosure increases camaraderie, puts people at ease, and gives them better quality information, transparent communicators are readily experienced as trustworthy (Ambrose, 2009).

**Phase 2: Interview**

The Zoom interview recordings were transcribed into a Microsoft Word document. The same number (1–20) assigned to participants questionnaire results was also assigned to the interview data. The approach made the participants easily identifiable while maintaining their confidentiality. The interview data were analyzed for common themes. The questions asked during the interviews were related directly to the four dimensions of trustworthiness. Themes were then identified within each of the four categories, which directly reflects the study findings specific to extrinsically imposed barriers that transition into self-imposed barriers.

## Results

The results of this study show there could be a combination of self-imposed hindrances that Black women place upon themselves along with limiting factors put upon them by others. Common themes based on lived experiences were identified: lack of trust in the workplace, lack of confidence, lack of opportunity with all being rooted in common experiences of limiting factors rooted in racism. In addition, during the interviews, additional themes emerged related specifically to the four ITP dimensions indicating limited transparency, extreme goodwill, strong integrity and commitment to competence. This resulted in 5 themes that are clear drivers for self-imposed leadership limitations for Black women in health care administration.

**Theme 1: Racism and Self-Imposed Barriers**

"I am (was) just tired," was expressed by 18 of 20 participants during their interview. When asked to elaborate, the theme of racism was clearly expressed. The interviewees felt their limitations in the workplace were due to their Caucasian counterparts not valuing them for who they are or for what they bring as strengths to their chosen professions. To repeatedly be told you don't have the needed education, experience, demeanor, and several other descriptors became tiring for many, so they eventually gave up on efforts to advance. The results being that they settled and accepting the limited management opportunity, transitioned to another health care organization, or completely left the health care industry to pursue self-employment.

Several participants equated their experiences in the workplace to that which is depicted in the current racial injustice seen related to police brutality. Study Participant #5 stated, "we die in the workplace, the same as Black men dying in the streets at the hands of the police." An example used by Participant #5 and all others reflected the acquiring of multiple degrees and certifications being met with new additional requirements before a promotion could be afforded. "When educational requirements are met, yet not recognized, Black women die in the workplace (Participant #4)." Participants #1, #3, #4, #5, #8 all indicated there is little to no value placed on the extra work that Black women do to be ahead of others who don't look like them.

As described by participants, continuing to push for something that seems so far out of reach is tiring which then becomes the self-imposed barriers that transferred from the discriminatory, unequal treatment, put upon them from others. Study Participant #3 indicated they begin to accept it, even if it's not right or accurate. She described it as the "concrete ceiling" put upon Black women in the workplace.

Study Participant #2 who self-identified as bi-racial, indicated she is frustrated with the on-going race issue in the workplace that no one is trying to address. She felt the systemic racism puts limits on brave space in the workplace to talk about the real issues that should be addressed. Study Participant #15 discussed Affirmative Action and the inequality in that which should have reflected greater inclusion for all yet only provided the greatest value for white women in the workplace.

**Theme 2: Lack of Trust of Caucasian Leaders and Colleagues**

Another important theme that surfaced was in regard to trust of others. Of the 20 Black female participants for this study, all 20 indicated trust of their white leaders and colleagues was none existent. The lack of trust for others was also linked to the ITP common theme of a lack of transparency in the workplace. Participant #14 stated, "You have to model trust before someone will trust you." This participant went on to indicate that Black people are more willing to model the behavior of trustworthiness than the white people they report to.

**Theme 3: Confidence in One's Capability and Competence**

Confidence in self and one's capabilities was a divided theme with extreme opposite perspectives among study participants. However, confidence in one's competence as a dimension of trust was a positive common theme. Study participants who held lower level positions discussed a lack of confidence that stemmed from the continued poor treatment by their managers. Even with the needed competence acquired through experience and education, there was still a lack of confidence. Participant #3 stated, "someone tells you something long enough, you begin to believe it."

For study participants who held higher levels of leadership, the aggregated thought indicates the importance of demonstrating confidence as a leader, even when you are not. Those

individuals indicated their confidence was a driver for their success and ability to move higher in leadership. Participant #14, the only Vice President level participant, indicated it takes confidence to rise, which requires you to build your knowledge and capabilities so you can show up as confident. This participant spoke about the importance of competence being acquired through formal education, but also the importance of competence of all areas of the health care organization. That display of subject matter expertise that goes beyond your chosen discipline is a key requirement for being a Woman of color in senior leadership.

For all 20 participants, the value of education and a commitment to continues learning was evident. Participant #8 stated, "Black women have to demonstrate more competence and credentials to be viewed as credible." Participant #8 also indicated over the course of her career, the only leader she had who acknowledged and place value on her education was another Black female. Participants #8 and 5# both indicated they made the decision to leave health care and pursue self-employment because of the continued lack of acknowledgment of their education and experience, as well as being denied opportunity for advancement.

**Theme 4: Limited Opportunity for Advancement**

Mentoring and relationship building was a common factor for advancement opportunity as indicated by all participants. However, several indicated the limited opportunities in their career growth was in ways linked to a lack of opportunity being made available as a result of unfair racist behaviors. All participants referred to this phenomenon as "the unspoken truth" in the workplace. The truth that Black women are in many ways devalued and overlooked for leadership but instead kept in positions because they are hard workers who will get the job done., far exceeding expectations. Study Participant #4 has been limited to her current frontline lead role for nearly 15 years and passed over for next level leadership on three different occasions.

At Year 8, for this participant, this constant rejection shifted her mindset. She took on the mindset that she would stay in her role and learn every possible thing she could learn about the role, so that when the time presents again for an interview, she would be able to demonstrate exceptional knowledge as a subject matter expert. The challenge with this thought process, while staying in the current role, she became the subject matter expert and all others, including managers, come to her to get information.

Competence was another important ITP dimension of trustworthiness for the study participants. All study participants had at least a bachelor's degree with 16 out of 20 holding a master's degree as well. All completed certifications and training programs for their respective discipline, however, all indicated at some point in their career they were passed over for opportunity with the roles going to white men or women with less education and experience. Participant #4 was never told she lacked the competence; each interview reflected a new requirement or concern that didn't exist before, such as, "Well, you are not approachable." The focus on being the subject matter expert then became for this participant the self-imposed barrier to leadership advancement triggered by the unfair treatment of others.

**Theme 5: Transparency Is a Difficult Dimension of Trustworthiness**

Although the greater focus for this study and the results are more focused on the interview data, there also was a demonstration of commonality with the ITP results. The ITP provided participants with an opportunity to self-assess their leadership trustworthiness across the four dimensions of trust: competence, integrity, goodwill, transparency.

All 20 study participants reflected exceptional self-ratings for goodwill, integrity and competence. Lower ratings for transparency was reflected with 100% of the respondents. The lowest ratings of 1 or 2 among 40% or more reflected support of the theme which surfaced

during the interviews of not being their authentic self in the workplace. Three questions were commonly referenced (see Table 1).

**Table 1**

*ITP Questions Most Commonly Referenced*

| ITP questions | % of ratings of 1 or 2 (least like me) |
|---|---|
| If someone asks me to do something I don't want to do, I'm comfortable saying no. | 55 |
| I am the same person at home and at work. | 40 |
| I disclose personal information so others can get to know me. | 50 |

*Note.* Table reflects the common lower ratings reflected at 40% or more.

The questions asked during the interview related to this lower self-rating from the ITP also yielded similar responses. Participant #1 stated, "If you are in an environment where there is no trust, you cannot be transparent." This thought also linked to integrity and commitment and how both are impacted by the lack of trust.

Several study participants indicated because of their lack of transparency, they never expose their true feelings in the workplace, even when it would be most appropriate. Because of the fact their transparency is low, managers never hear the feedback of how they feel they have been mistreated. In addition, they never ask the manager for the specific reasons why they were not afforded the opportunity for advancement in their effort to address any gaps.

Participant # 14, states this was identified as a strength early in her career. She stated, "You have to self-assess to get to the next level." For this participant this meant she needed to ask questions whenever denied an opportunity. She would write it down, work on it, then leverage the information in the next interview, to ensure the manager did not forget what they

shared as reasons for previous denials. She states, “You have to ask why so you can prepare, and remind them of the reasons they said no.”

## Chapter Summary

Chapter 4 provided information related to the results of this study. Data were collected in two ways. Participants first completed an online questionnaire, the ITP. Secondly, study participants were interviewed to better understand their lived experience. The results of the study reflected five common themes that reflect limiting factors for leaderships advancement of Black women in health care administration. Even with the needed trustworthiness dimensions of competence, goodwill, and integrity, the lack of transparence is rooted in a lack of trust of others. This lack of trust is a result of poor treatment by others in the workplace which often results in self-imposed barriers. Chapter 5 will provide recommendations to help address the identified concerns for Black women in leadership.

Chapter 5

Conclusions and Recommendations

The purpose of this qualitative descriptive case study was to identify self-imposed barriers of Black women's opportunities to attain executive administrative leadership positions and provide recommendations for overcoming such obstacles. Chapter 5 focuses on a discussion of the study findings by themes and recommendations for leadership and future study of this topic. The chapter also reviews the limitations, implications and conclusions.

## Research Questions/Hypotheses

The purpose of this qualitative descriptive case study was to identify self-imposed barriers of Black women's opportunities to attain executive administrative leadership positions and provide recommendations for overcoming such obstacles. The following research questions guided the study:

**RQ1.** What is the self-perceived level of trustworthiness of Black women who desire to obtain higher levels of administrative leadership as measured by the four dimensions of trustworthiness: competency, integrity, goodwill, and transparency?

**RQ2.** How does the perception of trustworthiness influence self-doubt and the potential for leadership advancement for Black women in health care administration?

**RQ3.** How might these issues be addressed as described by current Black female leaders based on their experience in their role and how they viewed themselves through the lens of the four dimensions of trust?

## Findings

The literature review for this study offered limited resources specifically focused on Black women in health care administration and the barriers to leadership advancement. This

provides minimal opportunity to compare and contrast however, there is sufficient information to support findings related to racism as an imposed limiting factor that exists in the workplace. As a result of this study, five themes emerged from this qualitative descriptive case study: (a) racism and self-imposed barriers, (b) lack of trust of leaders and colleagues, (c) confidence in one's capability and competence, (d) limited opportunity for advancement, and (e) transparency is a difficult dimension of trustworthiness.

These five items are viewed as barriers for Black women in health care administrative leaders, intrinsically and extrinsically imposed. The results have become known as the concrete ceiling. Concrete ceiling as referenced by study participants, refers to the challenges faced by women of color in rising to higher levels of leadership in the workplace.

**Themes 1, 2, and 4: Racism, Trust, and Limited Opportunities**

Discrimination still exists in the workplace (DeCelles, 2017). It is important that this fact be acknowledged and addressed to ensure marginalized individuals such as Black women are not overlooked for advancement opportunities. When overlooked as a result of racism, all to often, self-imposed barriers are then created. The outcomes from this study indicate that Black women feel they have limited opportunity for advancement because of racism. The participants of this study also indicate there is a lack of trust in the workplace which results in limited transparency.

Each of the 20 study participants indicated that Caucasians in leadership roles have limited them by indicating they need more education, more experience, to be more approachable along with many other factors. When Black women are told these things, they intern swiftly move forward to meet the new expectations, to still be told no for a new and different reason.

The feelings of study participants based on their lived experience supports the research as indicated by the Sullivan Commission on Diversity in the Healthcare Workforce (2004), the

reasons for the lack of diverse leadership include the single factor of racial and ethnic inequality. There have been limited leadership opportunities in the health care industry due to historical segregation in the United States (Sullivan, 2004; Watson & Rosser, 2007) and the efforts to integrate health care learning and work environments has lagged behind other industries (Bland, 2019; McGee Banks, 2000; Sullivan, 2004; Thew, 2019; Yancey, 2018). The current make-up of racial and ethnic minorities in health care roles such as physicians and nurses include less than 10% African American, Hispanic, and American Indian, others ("Diversity and Disparities," 2012; Sullivan, 2004). This study focused on the self-imposed barriers; however, this study shows, that the such barriers exists because of the inequality experienced by Black women in the workplace.

**Theme 3: Confidence in One's Capability and Competence**

The findings of this study appear to align with literature related to challenges faced by people of color in the workplace. Studies have shown that the shortage of health care workers in the past focused on increasing competence in health care specialties and administration for people of color; however, recruitment into higher levels of leadership still reflects low numbers ("Diversity and Disparities," 2012; Sullivan, 2004). All participants in this study indicated the importance of increasing their competence, however, they also indicated they have still been overlooked for opportunities based on racist practices.

This study also reveals a very important trait for a great transformational leader, confidence. The study participants indicated they are self-confident, however, in the workplace, due to being devalued, they do not show up as the full authentic self. This demonstrates a lace of self-confidence. Collins (2005) describes a good leader as one who achieves Level 5 Leadership. The ITP measures competence and the other 3 dimensions of trustworthiness, all with a focus on

self-confidence. The limitations put upon Black women in health care administration limits the self-confidence needed to be a great leader as described by Collins.

**Theme 5: Transparency Is a Difficult Dimension of Trustworthiness**

Ambrose (2009) indicates transparency is the most challenging area for minority leaders. The vulnerability being the reason which was validated by the 20 participants for this study. Trustworthiness requires transparency as a core capability. Through self-assessment the Black women in this study were able to identify this area as a clear self-imposed factor that hinders them from being trustworthy as transformational leaders in health care administration. They are not willing to openly share information in the workplace, even with the understanding of the importance of doing so to build trust as a leader. They want to know they are in a trusting environment before they are willing to expose any level of vulnerability.

## Limitations and Delimitations

There were minimal limitations identified for this study. The only clear limitation was the true availability of Black women in health care administration willing to participate in this study. There were expressions of concern related to anonymity as many thought the study would link to them and to their organization present or past. The only delimitation would be the participants would respond honestly and appropriately to the questions as presented.

## Recommendations to Leaders and Practitioners

The first recommendation for this study requires leaders to make significant changes in their organizational practices. Black women should be afforded the same opportunities for leadership advancement as their Caucasian colleagues. The results of such limitations have morphed into negative self-perception of leadership credibility for Black women.

To answer the first research question—What is the self-perceived level of trustworthiness of Black women who desire to obtain higher levels of administrative leadership as measured by the four dimensions of trustworthiness: competency, integrity, goodwill, and transparency?—the Black female participants of the study indicated they see a lack of trustworthiness based on how others see them across the four dimensions of trust and less on how they view themselves across the four dimensions. That fact has resulted in a lack of transparency out of the four dimensions yet has also resulted in self-imposed barriers based on self-doubt leading to stagnation. Death in the workplace as described by study participants. It is recommended that leaders removed the barriers and demonstrate fair and equitable practices in hiring and promoting in the workplace. Strategic focus efforts to end racism in the workplace is a requirement.

Question 2 relates to the self-doubt influenced by the perception of trustworthiness and it can be addressed and must be done so by Black females themselves. The transfer from others to self-imposed barriers can be reversed. The steps recommended for this to take place include first acknowledge this transfer from others to them has taken place. This requires ongoing assessment to understand the needed changes. From there, they will need to take action, creating a detailed action plan that will position them to advance by take proactive steps. This recommended approach is the 4-A Model for Self-Change and Action Planning:

1. Acknowledge – The transfer from others to you
2. Assess – Your needed changes
3. Action – Create an action plan
4. Advance – Take proactive steps

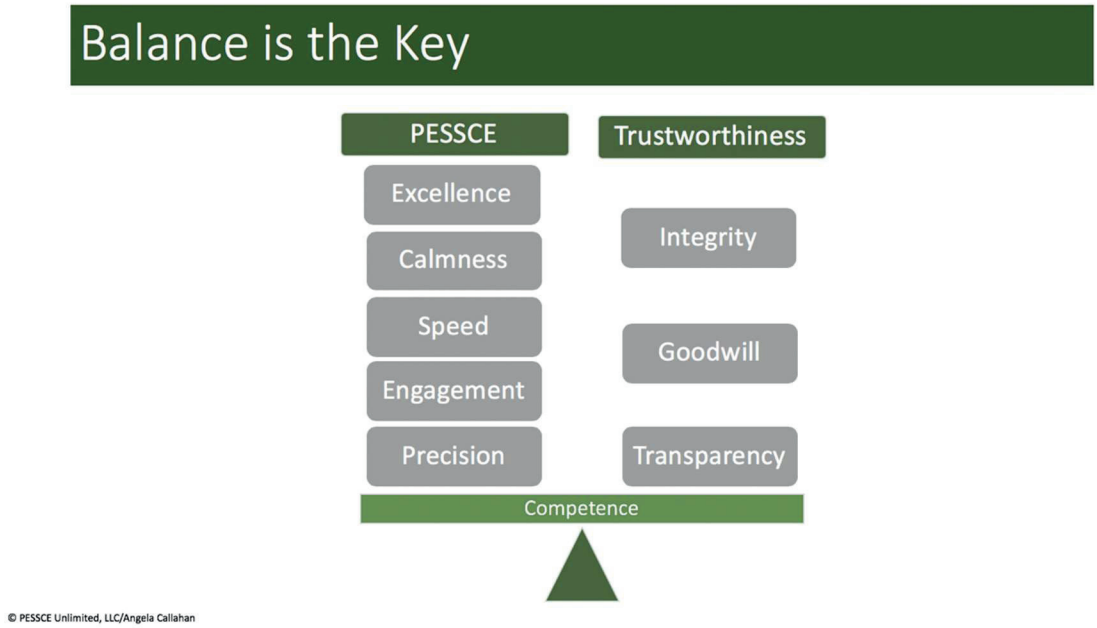
This study allows leaders to hearing firsthand from Black women who are prepared and desire to be in higher levels of health care administrative leadership, as well as those currently in

such roles. Past studies have focused on what leadership in organizations can do to be more inclusive (Pace, 2018; Thomas & Gabarro, 1999). This study supports that need, however there is opportunity for self-reflection to begin removing the self-imposed barriers brought on by others in the workplace.

The recommendations for this study are less for the senior-level leaders and decision makers within health care but more so for the Black female leaders seeking to advance in their career and ultimately reach the senior-level leadership positions. It is recommended that these leaders identify key leadership competencies to balance out the dimensions of trustworthiness. Recommendations are rooted in a leadership model with six competencies for leadership success for women of color. The competencies include excellence, calmness, speed, engagement and precision. These six competencies offer demonstration of capabilities as described by study participants that give the competitive advantage in the workplace.

**Figure 1**

*Balance*



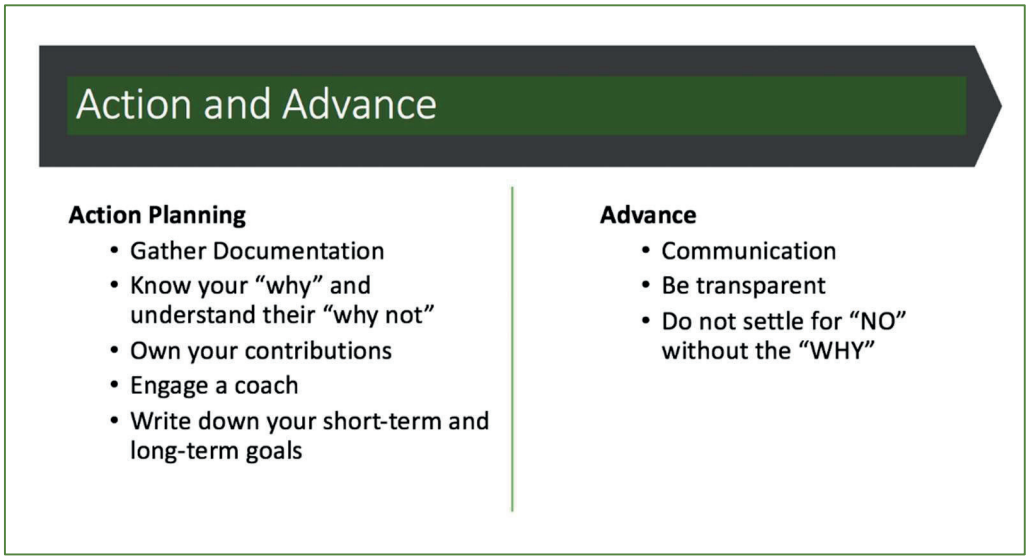

Study Participant #14, a retired Black female executive health care administrative leader, also provides recommendations on how these issues of leadership barriers might be addressed. She suggests that Black females in the workplace self-assess and determine where there are opportunities for change. Stay focused and push forward with confidence and building full competency of the health care organization. In addition, Participant #14, suggests that health care organizational leaders also self-assess to identify visible and invisible racist behaviors. They will be required to build out action plans that promote sustainable change in behavior.

There are very talented Black women and other people of color in health care administration who should be afforded the same opportunities as their Caucasian male and female counterparts. A recommended approach for Black female leaders would be to take action

to advance by including the recommendations from Participant #14 in a two-step approach. Taking action to advance will require specific tasks within this two-step:

**Figure 2**

*Take Action to Advance*




The intent of this study was to identify if there are self-imposed barriers to leadership advancement for Black women in the area of trustworthiness. The data indicates there are concerns and the recommendations in this section offers solutions for overcoming such obstacles. This qualitative descriptive case study combined a narrative analysis of semistructured interviews with a content analysis of questionnaire responses. The findings of this study show self-perception of credibility contributes to the lack of opportunity for leadership advancement for Black women in health care administration with a clear connection to limiting factors put upon them by Caucasian men and women in leadership in health care administration. Even with the imposed restrictions and challenges, the recommendations from this study focus on the needed efforts of the Black women to remove the barriers inclusive of challenging that which has been put upon them as limitations.

## Reflections

A key driver for my focus for this study was my own personal experiences. As a Black woman with experience in healthcare administration, I understand and can relate to the perspectives shared by the 20 women who participated in this study. My experiences of being devalued and overlooked showed up in many ways in the workplace, however, I persevered, and continued to climb. The study participants are me and I am them based on our common experiences. It is my hope that this study will give opportunity for a greater focus on addressing the unacceptable behaviors in the workplace towards Black women. Our experiences are real.

## Recommendations for Future Research

Given the glaring concerns of racial injustice in the workplace, recommended future research might be on how to end systemic racism in the workplace. This study focused on how Black women view themselves as leaders based on the four dimensions of trustworthiness. Focusing a study on how Caucasian men and women in leadership view Black women and other people of color might yield information to help address the concerns of racism in the workplace. This approach would still allow for self-assessment however, the view would be from those who are viewed as individuals who impose limitations on others.

## Summary

Chapter 5 focused on a discussion of the study findings by themes and recommendations for leadership and future study of the topic of Black women in healthcare administrative leadership. The research method used for this study was most appropriate as it yielded the expected results based on the lived experiences of the study participants.

This qualitative descriptive case study identified five themes as a result of data gathered through use of a questionnaire and interview administered to 20 Black female participants. With

the purpose of the study being to understanding the self-perceived credibility of Black women in health care administrative leadership the five identified themes that reflect the outcomes of this study included: (a) racism and self-imposed barriers, (b) lack of trust of leaders and colleagues, (c) confidence in one's capability and competence, (d) limited opportunity for advancement, and (e) transparency is a difficult dimension of trustworthiness.

The research questions have been answered as follows:

**RQ1.** What is the self-perceived level of trustworthiness of Black women who desire to obtain higher levels of administrative leadership as measured by the four dimensions of trustworthiness: competency, integrity, goodwill, and transparency? The Black female participants of the study indicated they see a lack of trustworthiness based on how others see them across the four dimensions of trust and less on how they view themselves across the four dimensions.

**RQ2.** How does the perception of trustworthiness influence self-doubt and the potential for leadership advancement for Black women in health care administration? Their perception is reality and there is a reflection of self-doubt, based on the poor treatment in the workplace that is the result of racial injustice. The result is self-imposed barriers a result of other's impositions. The transfer from others to self-imposed barriers can be reversed.

**RQ3.** How might these issues be addressed as described by current Black female leaders based on their experience in their role and how they viewed themselves through the lens of the four dimensions of trust? A recommended approach for Black female leaders would be to take action to advance. When not afforded opportunity action plan by gathering documentation, know their "why" and understand their "why not," own your contributions and engage a coach to

address, then write down their short-term and long-term goals. In addition, to advance, communicate, be transparent, and do not settle for "no" without the "why."

The focus of this qualitative descriptive case study was on the lived experiences of Black female midlevel healthcare leaders, and ascertaining how trustworthiness connected to self-assessment, transformational leadership and advancement opportunities. Based on the information shared by study participants, the lack of Black female senior-level leaders in healthcare organizations may be the result of their self-perception of credibility, however, that perception is based on their experiences of unfair treatment. Additional study of contributing factors to limitations placed on Black women in healthcare and other industries is recommended.

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Appendix A

Informed Consent

Consent for Participation in Research

I volunteer to participate in a research project conducted by Angela Callahan from the University of the University of Phoenix. I understand that the project is designed to gather information about the self-perception of Black female leaders in health care organizations. I will be one of approximately 20 people being interviewed for this research.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty. If I decline to participate or withdraw from the study, no one will be told.
2. I agree to complete the Interpersonal Trust Profile tool. I understand the completion of the questionnaire will take approximately 15-20 minutes to complete.
3. I agree to participate in an interview in person or via an online meeting platform. I understand that most interviewees will find the discussion interesting and thought-provoking. If, however, I feel uncomfortable in any way during the interview session, I have the right to decline to answer any question or to end the interview.
4. Participation involves being interviewed by a researcher from the University of Phoenix. The interview will last approximately 30-45 minutes. Notes will be written during the interview by the researcher. An audio recording of the interview and subsequent dialogue will be made. If I don't want to be recorded, I will indicate my choice to the researcher.
5. I understand that the researcher will not identify me by name in any reports using information obtained from this the questionnaire or the interview, and that my confidentiality as a participant in this study will remain secure.
6. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions.
7. Administrative leadership from my health care organization will neither be present at the interview nor have access to raw notes or transcripts from the interview or questionnaire. This precaution will prevent my individual comments from having any negative repercussions.
8. I understand that this research study has been reviewed and approved by the Institutional Review Board (IRB) for Studies Involving Human Subjects: Behavioral Sciences Committee at the University of Phoenix
9. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.
10. I have been given a copy of this consent form.

_____ _____

My Signature Date

_____ _____

My Printed Name Signature of the Investigator

For further information, please contact:
Angela Callahan, Principle Researcher
Phone: 617-755-0439, E-mail: acallahan70@gmail.com

Appendix B

Interpersonal Trust Profile

# Interpersonal Trust Profile--SELF




The *Interpersonal Trust Profile* (ITP) is designed to measure the degree to which we are "trustworthy" based on several observable behaviors. There are two versions of this tool: The ITP-SELF helps you reflect on your own values and behaviors as you relate to others. The ITP-OTHER allows those with whom you interact (e.g. colleagues, customers, supervisors or friends) to give you feedback on the frequency with which they observe you engaging in trust-building behaviors.

You can use the *Interpersonal Trust Profile* (ITP) to:

- Reflect on yourself or get feedback needed for your personal development efforts.
- Stimulate meaningful conversations and skill building during leadership, supervisory or interpersonal skills programs.
- Engage work teams or restore trust, especially following major organization changes.
- Assess your organization's climate and help you make informed choices as you lead culture change initiatives.

This instrument is based on research that formed the foundation for Delorese Ambrose's books, *Leadership: The Journey Inward,* and *Healing The Downsized Organization.*

# Interpersonal Trust Profile--SELF

**Developed by Delorese Ambrose, Ed.D.**

## SELF VERSION

| **Using a scale of 1 (NOT descriptive of me) to 4 (VERY descriptive of me), please rate yourself by writing (1, 2, 3, or 4) in the circle to the right of each statement:** | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 1. I stay abreast of the latest approaches in my field. | | | | |
| 2. If my viewpoint differs from the group's, I speak up and let others know what I think. | | | | |
| 3. I deliver on my promises. | | | | |
| 4. If someone asks me to do something I don't want to do, I'm comfortable saying no. | | | | |
| 5. I take the needs of others into account when I make decisions that may affect them. | | | | |
| 6. I make sure I can actually keep a commitment before I agree to it. | | | | |
| 7. I consistently get good results. | | | | |
| 8. I laugh at myself or admit my mistakes in the presence others. | | | | |
| 9. When I say or do something that causes hurt feelings, I attempt to restore the relationship. | | | | |
| 10. I seek feedback from others to change my behaviors for the better. | | | | |
| 11. I speak the truth as I see it. | | | | |
| 12. I enjoy serving others. | | | | |
| 13. I praise people for their contributions. | | | | |
| 14. I give honest corrective feedback to others. | | | | |
| 15. When someone disappoints me I talk *with* him or her directly (rather than talking *about* the person to others). | | | | |
| 16. I disclose personal information so others can get to know me. | | | | |
| 17. I treat others as *they* would like to be treated. | | | | |

# The Interpersonal Trust Profile--SELF

**Developed by Delorese Ambrose, Ed.D.**

## SELF VERSION

| | A | B | C | D |
|---|---|---|---|---|
| 19. I am resourceful in a crisis. | | | | |
| 20. I admit to others when I'm wrong. | | | | |
| 21. I communicate regularly with key colleagues, clients, family, and friends. | | | | |
| 22. The decision-making techniques I use get good results. | | | | |
| 23. I am the same person at home and at work. | | | | |
| 24. I listen to feedback non-defensively. | | | | |
| 25. When I give corrective feedback I tend to be more descriptive than judgmental. | | | | |
| 26. I honor confidential information shared with me by others. | | | | |
| 27. Others respect me for my expertise. | | | | |
| 28. I live and behave in a way that is consistent with what I *say* I believe in. | | | | |
| 29. When I change my mind, I let people know. | | | | |
| 30. I have a knack for influencing people positively. | | | | |
| 31. I actively seek out new skills/learning. | | | | |
| 32. When mistakes are made, I ask "what did we learn?" | | | | |
| SCORING | A | B | C | D |
| **COLUMN TOTALS:** | | | | |

# INTERPRETING THE PROFILE

**A. COMPETENCE:** ***Being reliable--embracing learning opportunities and consistently getting good results. Competence includes problem-solving and decision-making skills, an ability to implement effective changes, technical know-how, as well as the interpersonal or leadership skills needed to consistently achieve performance goals and objectives with and through others.***

**BEHAVIORS TO PRACTICE:**

- Listening, learning and *acting* on what's learned
- Applying technical, financial, and human resources wisely
- Asking the "right questions" in order to solve the "right problems"
- Taking initiative when appropriate
- Reliably getting the job done on time and well
- Regularly looking inward to reflect on lessons learned and apply the wisdom that comes from experience
- Reading people well and managing emotions effectively while working to serve clients or complete projects
- Actively seeking out learning opportunities.

---

**B. INTEGRITY:** ***Being honest, keeping promises and taking actions that match stated values and beliefs. Integrity literally means "wholeness."***

**BEHAVIORS TO PRACTICE:**

- Speaking the truth as you see it and inviting others to speak their truth
- Making ethical choices in dealing with others
- Making promises that are realistic and letting people know immediately if things change
- Admitting mistakes and weak points
- Checking to make sure that the impact on others is consistent with your intentions
- Consistently living stated values and vision so that your "walk" (what you do) is congruent with your "talk" (what you say you believe in).

---

**C. GOODWILL:** ***Caring about others and showing it. This dimension of trust, also labeled "benevolence," is a critical, but often overlooked, link to personal effectiveness. We demonstrate goodwill when we treat people as they would like to be treated.***

**BEHAVIORS TO PRACTICE:**

- Showing respect for colleagues and clients both personally and professionally
- Being fair and supportive when dealing with others
- Listening attentively even when others' viewpoints, backgrounds and experiences differ from your own
- Showing camaraderie and warmth
- Creating a sense of pride and team spirit by acknowledging people's accomplishments.

---

**D. TRANSPARENCY:** ***Communicating openly and disclosing true feelings. Because self-disclosure increases camaraderie, puts people at ease, and gives them better quality information, transparent communicators are readily experienced as trustworthy.***

**BEHAVIORS TO PRACTICE:**

- Sharing full information whenever possible, without violating confidentiality
- Communicating in a way that is open, unambiguous, and tailored to the needs of varying audiences
- Revealing true thoughts, feelings, expectations, and observations

# DO YOU VIEW YOURSELF AS A TRUSTWORTHY LEADER?

**A pre-requisite for a good leader who has followers, is trust. There are different styles of leadership, with all having similar core characteristics and capabilities. Trust is a core characteristic needed for any style. Followers want their leaders to be trustworthy. Trustworthy leadership reflecting interpersonal trust within an organization demonstrates positive interactions, removal of distrust, and fully functioning teams focused on overall organizational success. Based on your self-assessment results, please use the following scale to understand how trustworthy you view yourself as a leader.**

## Rating by Category

| | 32-28 | 27-23 | 22-18 | Below 18 |
|---|---|---|---|---|
| **A. COMPETENCE** | ☐ Committed to lifelong professional development.<br>☐ Confident, reliable as a change leader;<br>☐ Makes decisions effectively<br>☐ Demonstrates effective interpersonal communication | ☐ Focused on building needed competence for leadership<br>☐ Seeking opportunities for development and self-reflection regularly | ☐ Desires to learn however, lacks confidence in one's competence<br>☐ Complacent and comfortable in current roll with little aspiration for next level leadership | ☐ Demonstrates minimal leadership competence;<br>☐ Prefers not being in a leadership position<br>☐ Lack of commitment to professional growth<br>☐ No desire for leadership role |

| | 32-28 | 27-23 | 22-18 | Below 18 |
|---|---|---|---|---|
| **B. INTEGRITY** | ☐ Reflects honest behavior rooted in moral principles<br>☐ Upright and ethical in all interactions<br>☐ Honors confidentiality | ☐ Willing to commit but may do so without communication of true capability and capacity<br>☐ Thoughtful in giving consideration to others, however not always honest about true feelings or impacts | ☐ Not always able to distinguish between what is honest or dishonest by common standards of integrity<br>☐ Makes unrealistic commitments | ☐ Does not place integrity as a top priority<br>☐ May be dishonest in day to day interactions in the workplace<br>☐ Does not honor confidentiality |

| | 32-28 | 27-23 | 22-18 | Below 18 |
|---|---|---|---|---|
| **C. GOODWILL** | ☐ Demonstrates the "Platinum Rule" by treating others how THEY want to be treated | ☐ Committed to doing good while treating others the way YOU want to be treated | ☐ Considerate of others at time with a greater focus on self-preservation | ☐ Self-focused with little to no concern for others |

| | 32-28 | 27-23 | 22-18 | Below 18 |
|---|---|---|---|---|
| **D. TRANSPARENCY** | ☐ Communicates openly and discloses true feelings and appropriate | ☐ Focused on building transparency and sharing personal | ☐ Discomfort with exposure of personal thoughts, feelings and | ☐ Never fully shares information<br>☐ Violates confidentiality; |

Appendix C

Permission to Use an Existing Survey

UNIVERSITY OF PHOENIX

**PERMISSION TO USE AN EXISTING SURVEY**

Date 09/25/09

Angela Crutchfield
230 Willard Street, #508
Quincy, MA 02169

Dear Angela,

Thank you for your request for permission to use the Interpersonal Trust Profile (ITP) in your research study. We are willing to allow you to reproduce the instrument as outlined in your letter at no charge with the following understanding:

- You will use this survey only for your research study and will not sell or use it with any compensated management/curriculum development activities.
- You will include the copyright statement on all copies of the instrument.
- You will send your research study and one copy of reports, articles, and the like that make use of this survey data promptly to our attention.

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to us.

Best wishes with your study.

Sincerely,

Signature

**I understand these conditions and agree to abide by these terms and conditions.**

**Signed** _____ **Date** 9/29/09

**Expected date of completion** 5/1/11

AMBROSE
CONSULTING & TRAINING, LLC

## PERMISSION TO USE AN EXISTING SURVEY

Date 09/25/09

Angela Crutchfield
230 Willard Street, #508
Quincy, MA 02169

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- You will send your research study and one copy of reports, articles, and the like that make use of this survey data promptly to our attention.

If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to us.

Best wishes with your study.

Sincerely,

Signature

Phone: 404.378.5555
Fax: 404.378.6888
www.ambroseconsulting.com
225 East Ponce de Leon Ave, Ste 505

Appendix D

Interview Guide

**Trustworthiness Behavioral**
**Interview Questions**

The following questions will be used to interview study participants upon completion of the Interpersonal Trust Profile Questionnaire. Interview will be 1 hour in length.

1. Tell me about your leadership experience?
2. Tell me about your education and professional development that has prepared you for leadership?
3. How do you define competence?
4. What is the importance of integrity?
5. What is the point of goodwill in leadership?
6. Tell me about transparency in leadership?
7. How do you view your leadership capabilities in relation to the dimensions of trust?
8. How do you see your future as a leader?
9. What else would you like to share about your perception of trustworthiness/credibility
10. and the four dimensions of trust?
11. Why did you respond that way? *(Optional follow-up question: Use as follow-up for previous questions if needed)*

# Appendix E

## Study Recruitment E-mail

Hello,

I am **Angela Callahan, a doctoral student** working under the supervision of Dr. Leslie Huffman in the College of Doctoral Studies at the University of Phoenix. I will be earning my **Doctor of Management degree in Organizational Leadership** upon completion of my program. My study focuses on the self-perceived credibility of Black women in healthcare administration. This project will be conducted using purposeful sampling to identify Black female mid-level managers in healthcare organizations. This study will only include women who classify their ethnicity as black women *(woman of color, African American, etc.)*. There are no aspects of this study focused on colorizing race. The purpose of this study is to explore aspiring Black women's self-assessment of their leadership credibility utilizing the four dimensions of trust.

I am contacting you because of your current or past role in healthcare administrative management. I am hoping to hear from you about your self-perception of trust as a leadership criterion in healthcare administration. I am currently seeking volunteers as participants in this study who fit the following criteria:

1. Black women over the age of 21,
2. currently or were previously employed in a healthcare administrative role as a mid to senior level manager,
3. hold a minimum of a bachelor's degree or 5 years of leadership in a healthcare organization,
4. and who aspire to be in senior-level leadership.

**Participation in this study involves two things: 1. Completing a short questionnaire and 2. Participating in an interview. The questionnaire being used is The Interpersonal Trust Profile available through, Survey Lab through the following link:**

https://www.surveylab.com/pageTag/SurveyCampaign/cId/c0ac7767910d919229b80eee772a14f4c162dfb02/

**The completion of the survey will take approximately 15 minutes. The interview will be conducted upon completion of the questionnaire and will take approximately 45 minutes. Once you have completed your questionnaire, please click on the link below to schedule your interview. A Zoom meeting will be generated for the interview.**

https://calendly.com/pessce/research-interview-with-angela

There is no monetary compensation for participation in this study, however, **the results of your completed questionnaire will be provided to you at no cost.** I would like to assure you that the study has been reviewed and received ethics clearance through the University of Phoenix Institutional Review Board (IRB). The final decision to participate is yours. If you are interested in participating, please click on the link provided below to access the questionnaire, which includes an informed consent. Upon receipt