

PATIENT EXPERIENCES WITH HYPERTENSION IN THE GEORGIA STROKE AND  
HEART ATTACK PREVENTION PROGRAM

by

MARYLEN C. RIMANDO

(Under the Direction of JESSICA L. MUILENBURG)

ABSTRACT

Hypertension is a major public health problem today in the United States, affecting more than 73 million Americans or approximately 33% of the population. The purpose of the study is to understand the lived experiences of older adult patients diagnosed with uncontrolled hypertension. The site of data collection was the Northeast Georgia Health District Cardiovascular Health Clinic at the Clarke County Health Department. This clinic participates in the statewide Georgia Stroke Heart Attack and Prevention Program (SHAPP), implemented since 1974. The selection criteria of the sample ( $N = 29$ ) were White and African American male and female patients aged 55 and above, an active SHAPP client, and controlled or uncontrolled hypertension from the two previous clinic visits. Most participants were African American women. Semi-structured, in depth qualitative interviews were conducted with each patient. Common experiences included positive clinic experiences with the SHAPP nurse, compliance with medications, disbelief at the time of the first hypertension diagnosis, maintenance of healthy lifestyle behaviors, and negative experiences with previous private physicians. There were no differences found in the experiences of White and African Americans. In terms of gender differences, men reported less stress in their daily lives as compared to women. Overall, the

participants reported high self-efficacy and were empowered to control their blood pressure. These results can inform healthcare providers about the hypertension perceptions among African Americans in this sample and the successful stories of patients who incorporated lifestyle changes and have managed to control their blood pressure. These results will contribute to the understanding of hypertension from the patient's perspective and aid future efforts in designing culturally sensitive chronic disease management programs and educational tools to reduce the hypertension prevalence and improve the compliance rates among the African American adult population. The stories of these participants illustrate that older adults diagnosed with hypertension need to be treated as individuals with care, respect, and compassion particularly those populations who are low educated, unemployed, and uninsured.

**INDEX WORDS:** Hypertension, Older Adults, Qualitative Interviewing, Phenomenology, Noncompliance

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by

Marylen Cataquiz Rimando

B.A., Mercer University, 2005

M.P.H., Mercer University School of Medicine, 2007

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial  
Fulfillment of the Requirement for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GA

2010

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Marylen Cataquiz Rimando

Major Professor: Jessica L. Muilenburg

Committee: Dionne Godette  
Robert Galen  
Judith Preissle

Electronic Version Approved:

Maureen Grasso

Dean of the Graduate School

The University of Georgia

December 2010

## ACKNOWLEDGEMENTS

First and foremost, I thank God for guiding me through this journey of life and all of my education. None of my achievements are possible without you. “Grant me the serenity to accept the things I cannot change, change the things that I can, and the wisdom to know the difference.” You carried me through it all; now I see the light. Thank you. Life is a journey not a destination. I appreciate where you have taken me through all the many twists and turns. This point only marks the beginning. I will continue to quench my thirst for life-long learning. These three years were an unforgettable journey. I stand here especially grateful and very humbled.

I could not reach this place now in my life without these following people, each of whom I especially thank:

First, thank you to the faculty and staff in my department. I am grateful to receive the Ramsey Dissertation Award for this study. Three years ago, I was humbled by the opportunity to be accepted into this program. Now I stand here still humbled. These past three years have been life changing for me. My eyes have opened to a new world. I am very grateful for this opportunity and this has been a personally meaningful experience for me.

Thank you to my major professor Dr. Jessica Muilenburg for your support and advice. Thank you very much to my committee members Dr. Dionne Godette, Dr. Bob Galen, and Dr. Jude Preissle for all of your great guidance, encouragement, and patience throughout this journey. I wish success to your future doctoral students.

I am very grateful to the patients for their courage to share their stories with me and for allowing me to be a storyteller of their lives. I am inspired by your life stories. I especially thank the wonderful clinic staff for their patience and willingness to assist me in my recruitment.

I appreciate all your hard work, dedication, and support of my research.

Thanks to my students for opening my eyes to a new world these past three years. Teaching has changed me and shaped my perspective on life. It is beyond words I can express. I see the connections between the textbook, research, practice, and life. I appreciate all your insights and the stories you shared with me. It is rewarding to know our class has been beneficial to you in your life. I want to thank Dr. Carol Cotton for mentoring me and all the past TAs for sharing your great advice, insights, ideas, and your friendship over these three years.

I would like to thank Jeff, John, Karen, and Kristin and all my classmates in HPB and outside the department. I am thankful to have met you. Listening to all your advice, stories, and life experiences was an education in itself for me. I know what I have learned from you is beyond the textbook. Tina, you are a great person. Thanks for all your words of encouragement these last two years. It was great talking with you and sharing the office with you. I wish you the best in writing your dissertation and in the future.

Thank you to my cohort from the Future Faculty Program (Melinda, Jake, Matt, Lincoln, Greg, Josh, Diana, Jamie, Nicole, Lin, Erin, Christen, Luanna, and Nancy). I thank Dr. Paul Quick, Dr. Denise Domizi, and Dr. Cara Gormally for all your hard work, great stories, encouragement, and support of our dissertation writing and teaching this year. I am thankful to have met you all. Our Sapelo trip is among the highlights of this past year. Now I am still humbled to be chosen for FFP and have learned much from all of you. I wish you the best in your careers. FFP was truly unforgettable and thanks for all the great career advice, teaching tips, and stories. I will carry these with me.

Thank you to Dr. Miranda Pratt, my honors thesis advisor at Mercer University. You have been a great mentor to me. I still remember and use everything you taught me in my

research and teaching five years later. Thanks so much for teaching me about psychology, writing a research paper, and all of your career advice.

Stephanie, I am thankful we met five years ago. You are one in a million and one of the hardest-working, smartest, and most sincere people I have met. You are a great person, student and friend. Thanks for your support, encouragement, advice, our talks about cooking and food, and the phone calls. Good luck in finishing your classes and writing your dissertation. I know you will go very far in life and achieve great success in your career. I am here if you ever have any questions or if there is anything I can do to help in the future.

I would like to thank Dr. Tanisha Grimes for all your great advice about classes, teaching, and research since I first came to UGA. Thanks for being a great guest speaker in my class. You are a great mentor and teacher. I wish you success in your career.

Finally, I would like to especially thank my family. Thanks to my parents for all your support and encouragement throughout my life. My outlook on life has changed; I realize life is a journey in which I must learn from all the unexpected twists and turns. When one door closes another one opens. In the words of Ursula LeGuin, "It is good to have a journey to end towards, but in the end it is the journey that matters." Thanks for all your advice and teaching me about persistence, hard work, humility, and all the life lessons. I will remember these and carry these with me in life.

Last but not least, thanks to my brother. You are the smart one and a true genius. You possess many great talents and intelligence beyond measure. Thanks for your honesty, support, and encouragement. I know you will excel in whatever career you choose to pursue in life. Savor life through all the ups and downs. Appreciate wherever life takes you. Believe in yourself that you will succeed. Stay positive and grounded. Enjoy this journey of life. I know you will



achieve many great things this year. Wherever you are or go in life, I am here if you need me.

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## CHAPTER 1

### HYPERTENSION AMONG OLDER ADULTS IN THE UNITED STATES

An older adult may be defined as 65 and older and are among the fastest growing segments of the US population (Berkman, 2006). The Census estimates that the population of adults 65 and older will be 40.2 million in 2010, 54.6 million in 2020, and 71.5 million in 2020 (Forum, 2008). A rise in age-related cardiovascular diseases (CVD) is expected with the projected increase in the number of older adults (Berkman, 2006). Among older adults aged 65 and over in 2005-2006, the most prevalent chronic health condition was hypertension (53.3%), followed by arthritis (49.5%), and heart disease (30.9%) (Forum, 2008). As a result, an increase in populations over 65 in the United States is an expected to yield increase prevalence of hypertension.

Hypertension (HTN) or high blood pressure (HBP) is a major public health concern in the United States. According to the *Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (JNC 7) hypertension or high blood pressure for adults is defined as a systolic blood pressure (SBP) of 140 mm/Hg or higher and a diastolic blood pressure (DBP) of 90 mm/Hg or higher (Table 1) (Chobanian et al., 2004).

Table 1

#### *JNC 7 Definitions for Normal Blood Pressure, Pre-hypertension, and Hypertension*

<u>Category</u>	<u>SBP/DBP (mm/Hg)</u>
Normal	<120 / 80
Pre-hypertension	120-139/ 80-89

Hypertension	140/90
Stage 1	140-159/ 90-99
Stage 2	≥160/100

---

Patients identified with pre-hypertension are at a higher risk of developing HTN than those with normal blood pressure (BP). Interventions that help populations to adopt healthier lifestyles could reduce increased blood pressure, decrease the prevalence of HTN, or prevent HTN entirely in the future. Pre-hypertension is not a disease, but a designation to identify high risk patients so both patients and physicians are alerted to the high risk and can intervene, prevent, or delay the disease from developing (Chobanian, et al., 2004).

#### *Significance of Hypertension*

HTN is an important public health problem in the United States. According to the American Heart Association (AHA), approximately 73.6 million Americans aged 20 and older or 1 in 3 Americans have HTN (AHA, 2009a). Known as the silent killer, almost one fifth or 21.3% of individuals with HTN do not realize they have it. People surveyed with HTN reported they were aware of their condition (78.7%), were under treatment (69.1%), were controlling their HTN (45.4%), or unable to control their HTN (54.6%) (AHA, 2009b). Up to 95% of HTN cases stemmed from unknown causes, but the condition is easily detectable and can be controlled with appropriate treatment (AHA, 2009b).

Risk factors have been shown to be associated with hypertension in patients. Many people show no signs or symptoms of HTN, however the health consequences of HTN are important to recognize. According to the American Heart Association (AHA, 2009a), HTN is associated with a 2 to 3 higher risk of developing heart failure. Uncontrolled HTN increases



one's risk for stroke, which is the number three cause of death in the United States. HTN is a symptom of cardiovascular disease (CVD), which is the number one cause of death in the United States and Georgia. Other health consequences of HTN include end-stage-renal disease, kidney failure, arteriosclerosis, atherosclerosis, and chest pain (angina) (AHA, 2009a). Studies have shown increased risk for hypertension in patients who have risk factors such as obesity, smoking, diabetes, poor diet, and sedentary lifestyles. Needless to say, uncontrolled hypertension causes premature death.

There is recent statistical evidence of the enormous burden of hypertension in terms of clinical visits and medical costs. According to the CDC, in 2006, there were 44,879 million physician office visits for HTN. The estimated direct and indirect costs of HTN for 2009 were \$73.4 billion including direct medical costs and lost work productivity (CDC, 2006). In terms of hospitalizations, approximately 143,800 occurred among Georgia residents due to CVD, with the average length of stay of 5 days. The average cost per CVD hospitalization was \$30,700 in 2006. Total hospital charges for CVD increased by over \$1.6 billion between 2002 and 2006, from \$2.8 billion to \$4.4 billion. Direct and indirect costs of CVD are estimated at \$10.5 billion, which includes medical care and lost productivity from morbidity and mortality (CDC, 2009c).

Recent statistics from the Georgia Department of Human Resources (DHR) establish that HTN is an important public health issue in the state (DHR, 2008). Cardiovascular disease (CVD) is the leading cause of death in Georgia. The prevalence of adults in Georgia diagnosed with HTN increased from 21% in 1997 to 30% in 2007. In 2006, Georgia's CVD rate was 9% higher than the national rate. Also in 2006, CVD mortality rates were 1.4 times higher for men than women and 1.3 times higher for African Americans than Whites. African American men are at higher risk for premature death from CVD as compared to White men. Approximately one in two

African American men less than 65 years old died from CVD in 2006 (DHR, 2008).

### *Racial Statistics*

According to the National Health and Nutrition Examination Survey (NHANES) 1999-2004, Mexican Americans and non-Hispanic Whites were more likely to have normal blood pressure than non-Hispanic blacks (Ostchega, Yoon, Hughes, & Louis, 2008). The 2007 National Health Interview Survey (NHIS) reported that 31.7% of African American adults aged 18 and older were told they had HTN, compared to 25.5% of American Indian and Alaska Natives, 22.2% of Whites, and 19.5% of Asians (AHA, 2009a). Again, the 2008 NHIS data shows that 31.8% of African American adults aged 18 and above were told on two or more occasions that they had HTN, compared to 25.3% of American Indian and Alaska Natives, 23.3% of Whites, and 21.0% of Asians (AHA, 2009a).

The prevalence rates of hypertension in 2006 were 35.3 million males and 38.3 million females (AHA, 2009a). According to AHA (2009a), these hypertension prevalence rates were reported as follows (Table 2):

Table 2

### *Hypertension Prevalence by Gender and Race, 2009*

---

Gender	White	African American	Mexican American	Hispanic
Male	34.1%	44.4%	23.1%	20.6%
Female	30.3%	43.9%	30.3%	20.6%

---

As seen in Table 2, the Mexican American group is the only group which has comparable prevalence rates to that of Whites. Hypertension is highest among African Americans regardless

of gender (Table 2). From 1988-1994 to 1999-2002, HTN prevalence increased from 35.8% to 41.4% among African American adults, and specifically high in African American women (AHA, 2009a). The prevalence rate among Whites increased from 24.3% to 28.1% (AHA, 2009a).

Similarly, CVD mortality rates (per 100,000 population) remain high according to recent statistics (Table 3) (AHA, 2010):

Table 3

*CVD Mortality Rates by Gender and Race, 2006*

Year	Gender	White	African American
2006	Male	306.6/100,000	422.8/100,000
2006	Female	215.5/100,000	298.2/100,000

Source: AHA, 2010

The AHA (2010) stated that the overall death rate in 2005 from HTN was 19.4 per 100,000 of the population. These 2006 mortality rates (per 100,000) by race also reported (Table 4):

Table 4

*HTN Mortality Rates by Gender and Race, 2006*

Gender	White	African American
Male	15.6/100,000	52.1/100,000
Female	14.3/100,000	40.3/100,000

Source: AHA, 2010

In conclusion, these statistics demonstrate the differences in prevalence between the Whites and

African Americans with hypertension. African Americans appear to have the highest prevalence by gender (Table 4). Furthermore, these statistics show Whites as the most common comparison group in hypertension statistics by race, and Whites having the lowest hypertension rates among any racial group, while African Americans have the highest hypertension rates among other groups.

#### *Age Statistics*

The following statistics demonstrate the compelling burden of hypertension, especially in the older adult population. According to data from the National Center of Health Statistics (NCHS), the prevalence of hypertension increased with age from 7% among those aged 18-39 years to 67% in those aged 60 and older (Ostchega, et al., 2008). From ages 45-54 and 55-64, the percentages of hypertensive men and women are similar. After age 65, a much higher percentage of women have HTN than men (AHA, 2009a). Approximately those older than 60 years of age are hypertensive (Berkman, 2006). According to AHA's (2009a), 2005-2006 NHANES data, these hypertension prevalence rates were reported by age and gender (Table 5):

Table 5

#### *Hypertension Prevalence by Gender and Age Group, 2005-2006*

---

Gender	20-34	35-44	45-54	55-64	65-74	75+
Male	13.4%	23.2%	36.2%	53.7%	64.7%	64.1%
Female	6.2%	16.5%	35.9%	55.8%	69.5%	76.4%

---

Source: AHA, 2009a

According to 2003-2006 data from NHANES, hypertension prevalence rates were reported for the following older adult age groups (Table 7) (AHA, 2010):

Table 6

*Hypertension Prevalence by Gender and Age Group, 2003-2006*

Gender	Age Group		
	55-64	65-74	75+
Male	53.2%	65.4%	64.6%
Female	54.1%	70.8%	77.3%

Source: AHA 2010

These statistics in Table 6 above show that the rates of hypertension among older adults aged 55 and older is higher compared to the age groups below 55 in Table 5.

Similar to the previously mentioned prevalence rates, the following statistics report low hypertension control among Americans older than 60 compared to those younger than 60. Among treated hypertensives, those aged 18-59 years (72%) were more likely to have controlled their blood pressure than those 60 years and older (58%) (Ostchega, et al., 2008). Within the 60 years and older age group, hypertension control was significantly higher among men (64%) compared to women (53%) (Ostchega, et al., 2008). Based upon a sample from the Framingham Heart Study, hypertension control rates declined with increasing age for men and women (Lloyd-Jones, Evans, & Levy, 2005). Men aged 60-79 and 80 years and above reported lower control rates (48% each respectively) than those less than 60 years of age (68%). Similarly, women aged 60-79 and 80 and above reported lower control rates than those less than 60 years of age (68%). These low hypertension control rates among older Americans suggest the need to explore potential factors and lived experiences that influence the development, progression, and control

of hypertension among older adults.

### Factors Influencing the Risk of Hypertension

Researchers have identified behavioral risk factors associated with hypertension prevalence. Previous research has contributed to a greater understanding of hypertension as influenced by a complex interaction of factors on the individual, family, and community levels. It is important to discuss these influencing factors since patients with undiagnosed, untreated, and uncontrolled HTN place a substantial financial strain on the health care delivery system and experience avoidable morbidity and mortality. Variance in HTN outcomes across races and age groups may be attributable to differences in diet, exercise, access to health care, compliance and noncompliance with treatment, differences in socioeconomic (SES) conditions, attitudes and beliefs about their health and health-related information.

#### *Nutrition*

According to the Centers for Disease Control and Prevention, a diet of at least five servings of fruits and vegetables daily is recommended to lower blood pressure and the risk of heart disease and stroke (CDC, 2009b). Whole grains, whole fruits, and boneless skinless grilled chicken breasts are examples of recommended foods that patients should consume to replace fried and processed foods and lower blood pressure. From the standpoint of nutrition, the following may be associated with HTN: consuming a high sodium diet, high fat, high cholesterol, and high carbohydrate diets (CDC, 2009b).

Americans as a whole are not consuming the recommended amounts of fruits and vegetables according to recent statistics. U. S. government officials recommended for 2010 that at least 75% of Americans should eat at least 2 fruit servings daily and at least 50% eat three vegetable servings daily (CDC, 2009d). About 27% of adults consumed at least three vegetable

servings daily and 33% consumed at least two fruit servings in 2009 (CDC, 2009d). Adults 60 years and older reported not consuming the recommended amounts of fruits and vegetables (Greene et al., 2008). The Healthy Eating Index (HEI) evaluates the diet quality of older adults, and the 2001-2002 report shows that adults 55 and older are lacking in consumption of dark green and orange vegetables and legumes and whole grains (Forum, 2008). This information is useful in planning nutritional interventions and educational objectives focusing on the older adult population.

For older adults, the intake of fruits and vegetables in their diet may be negatively influenced by a multitude of complex interacting factors which distinguish them from younger adults (Berkman, 2006; Greene, et al., 2008). These barriers to the optimal food intake include changes in physical, economic, or cognitive status; management of multiple medical issues and medication regiment; shifts in social, family, or working environments; access to nutrition programs and age-related changes to taste and smell of foods. It is important to identify and address these complex factors and experiences specific to older adults in order to better understand and treat their complex chronic conditions such as hypertension.

### *Physical Activity*

The Department of Health and Human Services' (DHHS) 2008 Physical Activity Guidelines for Americans recommended a minimum of two hours and 30 minutes a week of moderate intensity physical activity such as brisk walking for adults and older adults with no health conditions (DHHS, 2008). Lack of regular exercise is a risk factor for chronic diseases such as hypertension, diabetes, stroke, and heart disease (DHHS, 2008). The relative risk of coronary heart disease associated with physical inactivity ranges from 1.5 to 2.4, an increase in risk comparable to high cholesterol, hypertension, or cigarette smoking (DHHS, 2008).

Recent statistics suggest a trend in physical inactivity among adults. The National Center of Health Statistics reported that 31.9% of adults engaged in regular, leisure physical activity compared to 29.8% (NCHS, 2008). Also NCHS reported that 37% of adults did not engage in leisure physical activity (NCHS, 2008). Additionally the 2008 National Health Interview Survey (NHIS) reports that the percentage of adults who engaged in regular leisure-time physical activity decreased with age (CDC, 2009a). Based on the data from the 2005-2006 NHIS, the prevalence rates of adults aged 65 and above who engaged in regular leisure-time physical activity were: 15.8% for Hispanics, 22.7% for non-Hispanic Whites, and 13.5% for non-Hispanic Blacks (Forum, 2008). In 2006, these older adult age groups reported these activities (Table 7):

Table 7

*Prevalence of Self-Reported Activities among Older Adult Age Groups, 2006*

Reported Activities	Age Groups		
	55 – 64	65-74	75 and older
Watching tv	53%	55%	54%
Reading	10%	11%	14%
Relaxing and thinking	7%	7%	11%
Sports, Exercise, Recreation	4%	4%	2%
Socializing, Communicating	13%	10%	10%
Other leisure activities (traveling)	13%	12%	10%

Source: Forum, 2009

These statistics definitely demonstrate a lack of regular physical activity in the older adult population (BLS, 2009). In light of this information, there is a need to understand the



experiences surrounding physical inactivity in order to promote physical activity among older adults and understand its possible influence on the development of chronic conditions such as hypertension.

### *Access to Health Care*

The National Coalition on Health Care (NCHC) reported that approximately 46 million Americans or 18% of the population under the age of 65 has no health insurance (NCHC, 2009). A recent study also reported that more than 4 million adults aged 55 to 64 were uninsured, and the number has likely increased since the recession (Jacobson, Schwartz, & Neuman, 2009). The Kaiser Family Foundation (KFF) reported that 1.66 million in Georgia were uninsured or 19.3% of the state population (KFF, 2009). On average, the uninsured are 9 to 10 times more likely to forgo medical care such as treatment for hypertension because of cost and twice as likely to have medical debt. Data from the 2006 National Health Interview Survey (NHIS) reveal that among adults aged 55-64, 75.4% had private insurance and 10.8% were uninsured (NHIS, 2006). Although fewer older adults are uninsured, 25% of older adults report poor health compared to 22% of younger adults (NHIS, 2006). Older adults are more likely than younger adults to have health problems, difficulty in finding affordable health coverage, and in seeing a health care provider. More than half of the uninsured population age 55-64 did not receive the health care they needed due to high costs (NHIS, 2006).

As stated by Berkman (2006), lack of insurance compromises the health of the uninsured. The uninsured receive less preventive care, have illness diagnosed at more advanced disease stages, tend to receive less therapeutic care after diagnosis, are unable to be seen by a health care provider for chronic health conditions, and eventually have higher mortality rates than the insured. The continual lack of access to health care for older adults may result in future

hospitalizations with higher financial costs, compared to receiving preventive care at an earlier stage. Additionally, this lack of access to health care may increase physical, psychological, and environmental stressors which contribute to the risk of hypertension (Berkman, 2006). Safety net hospitals and low-cost health services from the public health department provide a low-cost means of offering health care to those low-income populations who are unable to purchase insurance or pay for expensive medical services (Berkman, 2006).

### *Noncompliance*

Medication adherence or compliance is defined as “the extent to which a person’s behavior—taking medications, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider” (Fincham, 2007, p. 27). Compliance is patient behavior being congruent with health care providers’ recommendations. However, compliance remains a complex issue from the perspective of patients and physicians.

Noncompliance is a formidable public health issue for hypertensive patients. Regardless of drug therapy, patients must be motivated to control their HTN and to stay on their treatment plan as prescribed. Numerous factors such as positive patient experiences with a physician, patient’s trust in a physician, empathy on the part of a physician, support group, and financial aid can improve the patients’ motivation to manage their HTN (Fincham, 2007).

One segment of the population prone to noncompliance is older adults (Fincham, 2007). Many older patients have multiple chronic diseases requiring complex treatments over time to prevent complications and disability. Older adults are the greatest consumers of prescription medications (Fincham, 2007). According to a study analyzing data from the National Center of Health Statistics (NCHS), approximately 28% of adults with prehypertension were not following management to lower their BP (Ostchega, et al., 2008). Studies show mixed evidence on whether

there are differences in noncompliance between African American and White patients with hypertension (Kressin et al., 2007). A patient's failure to follow medical recommendations and treatment may lead to unnecessary complications, increased spending for future health care dollars, disability, and premature death.

A physician must consider a multitude of factors when deciding on optimal hypertension therapy (Chobanian, et al., 2004). They may fail to combine medications correctly and may not discuss necessary lifestyle changes. A clinician who is focused only on treating patient symptoms and who's lack of familiarity with the *JNC 7* or other clinical guidelines, may be clinical problems that need to be addressed and overcome. Also, physicians may have difficulty communicating or collaborating with nursing staff or other health care professionals to influence and reinforce patient instructions (Chobanian, et al., 2004). The other health care professionals involved may include physician assistants, pharmacists, nutrition educators, diabetes educators, optometrists, and podiatrists. Noncompliance may occur if health care professionals fail to demonstrate a commitment to HTN control by not reinforcing messages about behavioral risk factors for HTN, importance of managing BP and achieving a target BP, education about lifestyle interventions (Chobanian, et al., 2004).

From the patient standpoint, numerous barriers may prevent compliance from occurring. Patient attitudes are greatly influenced by cultural differences, personal or family beliefs, and previous experiences with the health care system (Chobanian, et al., 2004). Patients may misread the instructions on their medication bottles or not understand the physician's treatment and lifestyle recommendations during their clinic visit. Failing to understand a patient's educational background and health literacy may be a barrier to communication and understanding terms like hypertension and lifestyle modification. Chronically ill patients may stop taking medications if

they encounter economic constraints (Fincham, 2007). Physicians, nurses, and other health care professionals should not only understand but also respect their patients if they want to improve trust, improve communication, and improve treatment outcomes with patients and their families.

As described by Chobanian et al. (2004), a cluster analysis of 727 patients with HTN found that the individuals could be classified into 4 categories, listed as follows. The first group was health-oriented, knowledgeable about HTN, and took their medication. The second group relied on medication rather than lifestyle to control their HTN. The third group had the highest Body Mass Index (BMI), did not maintain a healthy lifestyle, forgot to take their medications, and had a lower HTN control rate. This group benefited from counseling, help with achieving lifestyle changes, and more frequent office visits or contact with nurses or other providers. The last group was male, not knowledgeable about HTN, and not afraid of HTN's consequences. Also they were most likely to consume alcohol, abuse tobacco, and stop medications without informing their physicians. This group required continual reinforcement, information on hazards related to BP control, small goal setting by health care professionals, and positive support by family and social networks. Maintaining a healthy lifestyle influences medication compliance as well as a patient's beliefs and involvement with food, beverages, physical activity, maintaining a healthy weight, salt and alcohol consumption, and smoking (Chobanian, et al., 2004). Optimal management strategies may be influenced by personality type, family members, and social networks (Chobanian, et al., 2004).

Failure to utilize goal setting and patient empowerment may contribute to noncompliance (Chobanian, et al., 2004). If the physician and patient do not agree on the BP goals and the timeline of achievement noncompliance may occur. If the patient does not feel empowered to make the behavior changes and does not understand the positive benefits of the behavior

changes, then noncompliance may occur. Health care providers and public health professionals should identify the explanations for medication adherence in order to create and reinforce the appropriate treatment for the patient.

According to Chobanian et al. (2004), economic barriers may contribute to patients' noncompliance with treatment. Patients may also experience difficulty paying for transportation to and from the clinic, hospital, and pharmacy. Expensive costs of medications and patients' perceptions that lifestyle changes may be barriers to compliance. Patients may perceive tangible costs as barriers instead of considering the potential benefits such as improved quality of life, taking fewer medications, lower health insurance costs, fewer medical visits, and longer life expectancy (Chobanian, et al., 2004).

#### *Challenges for Older Adults with Hypertension*

Hypertension has important implications for the physical, psychological, social, and environmental health of older adults. Uncontrolled hypertension is a major risk factor for heart disease, diabetes, and stroke (AHA, 2009a). According to Berkman (2006), older adults may experience a change in their environment, whether recently retired from the military or workforce, living alone in a nursing home, or feeling the physical and emotional burden as caretakers for a spouse or grandchildren. Furthermore, social consequences may exist in society for older adults diagnosed with hypertension. They may lack knowledge in cooking healthy meals, be financially dependent on younger family members for grocery chores, and feel isolated from socializing with their family and friends who may consume salty, fried, and processed foods (Berkman, 2006).

### *Living with Hypertension*

Older adults diagnosed with hypertension may experience changes in their daily lifestyle and activities, including their diet, physical activity, access to health care, and change to retirement (Berkman, 2006). Furthermore, hypertension patients may be concurrently managing other chronic diseases such as obesity or overweight and diabetes (Chobanian, et al., 2004). These other health issues may increase the stress level of patients and contribute to the difficulty of controlling their hypertension. The complex nature of these multiple health issues can be further investigated through qualitative research by capturing the detailed experiences and attitudes of hypertension patients (Creswell, 2007; Rossman & Rallis, 2003). Qualitative methods are a well-suited methodology for this study in order to gain an in-depth understanding of older adults living with hypertension and insights into the experiences of daily health behaviors from the patient's perspective (Moustaskas, 1994; Munhall, 2007).

### *Purpose and Rationale*

The purpose of the study is to gain an in depth understanding of the lived experiences of patients living with hypertension. For this project, my target population will be older adults aged 55 and above diagnosed with hypertension and currently attending a hypertension clinic adjacent to a large southeastern university. Participants at the time of the study will have either controlled hypertension (<140/90 mm Hg) or uncontrolled hypertension (>140/90 mm Hg) according to their medical records in the last two visits, and be White or African American, which are the two predominant racial groups at the hypertension clinic. Exclusion criteria included participants who did not speak fluent English, had multiple chronic diseases other than diabetes, and lacked the cognitive ability to complete the interview. In order to gather rich, qualitative data, individual semi-structured interviews were conducted with each participant on their experiences living with

hypertension and maintaining a healthy lifestyle. Phenomenological analytic techniques were used to analyze the interview data.

### *Research Questions*

To frame the study, the following questions were posed:

1. What are the lived experiences of older adults diagnosed with hypertension?
2. What are the differences in the experiences between Whites and African Americans?
3. What are the differences in the lived experiences between men and women?

## CHAPTER 2

### REVIEW OF THE LITERATURE

This chapter describes a review as well as critique of the literature as related to hypertension. Particularly, this chapter is organized as follows: 1) previous interventions and programs, 2) psychosocial determinants of hypertension, 3) noncompliance, 4) health behavior theoretical constructs, and 5) phenomenology. First, well-known interventions and programs are discussed to present a historical background of the literature. Next, health behavior theoretical constructs are discussed to provide a solid foundation for the conceptual framework of phenomenology and connection to the methodology in Chapter 3.

There are multiple attitudes, behaviors, and knowledge that may impact hypertension. These include stress, depression, lack of social support, and noncompliance to prescribed treatment (Bosworth, Bartash, Olsen, & Steffens, 2003; Fincham, 2007; Gascon, Sanchez-Ortuno, Llor, Skidmore, & Saturno, 2004; Jokisalo, Kumpusalo, Enlund, & Takala, 2001; Pilkington, 1999). These attitudes, behaviors, and knowledge may be influenced by personality, family, friends, social support systems, current or previous employment, and life experiences (Boutain, 1997; Boutin-Foster, Ogedegbe, Ravenell, Robbins, & Charlson, 2007; Burke et al., 1992; Curtis, James, Raghunathan, & Alcer, 1997; Gorman & Sivaganesan, 2007). It is crucial to identify these attitudes, behaviors, and knowledge in order to prevent the development of hypertension among White and African American adults and design programs and interventions to lower the rates of hypertension among older adults.

Theoretical constructs from the Health Belief Model, Theory of Reasoned Action and Theory of Planned Behavior are reviewed to determine their associations with hypertension in



previous studies. The salient constructs include perceived susceptibility, perceived benefits, self-efficacy, behavioral intention, and motivation to comply. Knowledge of the nature of these associations or lack thereof may assist in planning future programs and designing interventions.

#### *Previous Etiological and Intervention Studies*

Previous well-known CVD prevention interventions include 1) the Framingham Study, 2) the Pawtucket Heart Health Study, 3) the Jackson Heart Study, 4) the Minnesota Heart Health Program, and 5) the Stanford Five City Program. Below is a description of each of the major CVD prevention programs with the strengths and limitations of each. Table 8 illustrates the major points summarizing each major CVD prevention program.

The Framingham Study, a pioneering CVD study, began in 1948 and is currently ongoing. The objective was to identify the common characteristics of CVD by following a large group over a long period of time with no symptoms of CVD and who did not suffer a heart attack or stroke (Levy, 2009). Each generation has been recruited from age 30-62 that have a first round of physical examinations and lifestyle interviews that are repeated every two years. Results from the Framingham study indicate the following risk factors for CVD: hypertension, cholesterol, smoking, diabetes, obesity, and physical inactivity (Levy, 2009). Strengths of this study include following a cohort across the many decades of studying and identifying important CVD risk factors which are currently discussed by clinicians. Limitations include a sample consisting of an entirely White population from a single community in one state. Hypertension also was not a primary focus and outcome, but rather CVD.

The Pawtucket Heart Health Program (PHHS) is an intervention aimed at the primary prevention of CHD in a Rhode Island community (Elder et al., 1986). The purpose was to determine if community-based efforts to lower CVD risk factors reduce CVD morbidity and

mortality (Lefebvre, Lasater, Carleton, & Peterson, 1987). Program staff cooperated with local organizations to promote behavior change among community residents by applying social learning and community organization theories (Elder, et al., 1986; Lefebvre, et al., 1987). Lay volunteers recruited from the community were involved in the planning, implementing, evaluating, and managing of PHHS (Roncarati, Lefebvre, & Carleton, 1989). Strategies which increased awareness of CVD and risk factors were point of purchase nutrition education in supermarkets, Heart Healthy Cook Off, and telemarketing of preventive health behaviors (Carleton et al., 1991; Hunts et al., 1990; Schwertfeger, Elder, Cooper, Lasater, & Carleton, 1986). Strengths include the use of primary prevention for CVD and community based participatory research. Limitations include not evaluating the program after its completion through qualitative methods by interviewing participants and intervention staff on their experiences before and after the intervention. Also another limitation is sampling from a single community in one state. Hypertension also was not a primary focus and outcome, but rather CVD.

The Minnesota Heart Health program was a 13-year community-based program of mass media, community organization, and direct education targeted towards Minnesota youth to improve their cardiovascular health and prevent CVD in three communities (Kelder, Perry, Lytle, & Klepp, 1995; Luepker et al., 1994; Perry, Griffin, & Murray, 1985). Improved diet, exercise, and lowered hypertension were the program's main objectives (Perry, et al., 1985). The prevalence of major cardiovascular risk factors and hypertension were determined from program data (Nothwehr, Elmer, & Hannan, 1994). Results indicated that the program was modestly effective for the target groups in size and duration, since knowledge, healthy food choices, and restraint in high sodium intake were significantly higher in follow-ups compared to baseline

(Kelder, et al., 1995; Luepker, et al., 1994). Data indicates that health promotion messages can influence the public's understanding of heart disease and community involvement to reduce its risk factors (Pavlik, Finnegan, Strickland, & Salmon, 1993). Strengths include sampling from three communities in one state and the utilization of different methods of mass communication, community based participatory research and education. Limitations include no use of qualitative methods to interview participants on their health needs and experiences before, during, and after the program. Also, older adults were not the target population of the study, but rather youth.

The Jackson Heart Study is an etiological study of traditional and emerging risk factors for the progression of CVD (H. Taylor, 2005; H. Taylor, Hughes, & Garrison, 2002). The study population focused on an African American population in a metropolitan southeastern U. S. city (H. Taylor, 2005). Data indicated that improved hypertension control rates can be achieved among African Americans (Wyatt et al., 2008). The study's outcomes focused mainly on biomarkers and clinical measures (Akyzbekova et al., 2009; Deo et al., 2009; Fox et al., 2008; Samdarshi et al., 2009; Talegawkar et al., 2009). The method of measuring the presence and impact of sociocultural factors was discussed (Payne et al., 2005). Additionally, authors tested the psychometrics of a survey measuring perceived discrimination of participants in the Jackson Heart Study (Sims, Wyatt, Gutierrez, Taylor, & Williams, 2009). Strengths include the identification of biomarkers and clinical measures for the progression of CVD. Limitations include the use of a predominately African American sample and no use of qualitative methods to interview participants on their health needs and experiences before, during, and after the program.

The Stanford Five City Multifactor Risk Reduction Project (FCP) was a 14 year experimental study testing the effectiveness of a comprehensive intervention on CVD prevention

(Farquhar et al., 1985). FCP is a program that organized and educated communities toward stroke and heart disease prevention with existing community organizations. Treatment and control cities were compared for pre to post changes in knowledge of CVD risk factors and clinical measures (Farquhar et al., 1990; M. A. Winkleby, Taylor, Jatulis, & Fortmann, 1996). In addition, social class disparities and socioeconomic status were also compared among FCP participants (M. Winkleby, Fortmann, & Barrett, 1990; M. A. Winkleby, Jatulis, Frank, & Fortmann, 1992). Increased knowledge of CVD, risk factors, and behavior changes occurred after implementing FCP (M. A. Winkleby, Feldman, & Murray, 1997; M. A. Winkleby, Flora, & Kraemer, 1994; M. A. Winkleby, et al., 1996). Strengths include the many years of conducting the intervention and the collaborations with existing community organizations. Limitations include a lack of qualitative methods to interview participants on their health needs and experiences before, during, and after the program, and to interview the program staff about their experiences on designing and implementing the program.

*Summary of prior interventions focused on reducing blood pressure or controlling hypertension*

Overall, the five notable interventions and programs have successfully identified CVD risk factors and increased awareness of CVD knowledge. The majority of these studies included a sample of only White adults. The Jackson Heart Study included a sample of African American adults. Weaknesses of these studies as a whole included the lack of a racially diverse sample, lack of a qualitative evaluation component of the intervention, and the possibility of external and environmental factors influencing the behaviors of the participants. Hypertension also was not a primary focus and outcome, but rather CVD. While majority of these studies included the vast range of adults aged 18, older adults were not specifically the target population.

While it is important to identify hypertension risk factors and increase awareness of

CVD, I must first understand the lived experiences of people living with hypertension and gain insight into the context in which these health behaviors occur. An in-depth exploration into the lived experiences and health behaviors may provide insight into factors influencing the development of hypertension. Also conducting a study focusing only on older adults diagnosed with hypertension as a focus rather than CVD will add to the current literature.

Table 8

*Summary of Etiological and Intervention Studies*

Name of Study	Purpose	Sample	Design	Results	Limitations
Framingham	Identify common CVD characteristics	White	Cohort	Identified multiple CVD risk factors	All White sample in a single community, no qualitative design
Pawtucket Heart Health	Lower CVD risk factors and mortality/morbidity by community efforts	White	Non-randomized intervention	Increased CVD awareness and risk factor knowledge	No qualitative design
Jackson Heart	Identify traditional and emerging risk factors for progression of CVD	African American	Etiological	Improved HTN control for African Americans	African American sample and no qualitative design
Minnesota Heart Health	Prevent CVD and improve cardiovascular health	White	Quantitative	Modestly effective as knowledge and nutrition improved after baseline	Qualitative interviews before and after intervention with participants and program staff
Stanford Five City Project	Test effectiveness of a comprehensive intervention on CVD prevention	White	Quantitative	Increased knowledge of CVD, risk factors, behavior change occurred	Qualitative interviews before and after intervention with participants and program staff

*Nutrition, Physical Activity, and Access to Care*

Table 9 illustrates the summary of the literature on nutrition, physical activity, and access to care. A notable diet recommended for hypertensive patients and often studied in the literature is the Dietary Approaches to Stopping Hypertension (DASH) diet (Appel et al., 1997; Sacks et al., 2001). The DASH diet is low in sodium and high in fruits, vegetables, and low fat dairy products. Also, after consuming a DASH diet low in sodium, participants had decreases of 11.5 mm Hg mean systolic blood pressure readings among patients with hypertension (Sacks, et al., 2001). Another intervention in which participants consumed a DASH diet reduced their systolic and diastolic blood pressure by 5.5 mm Hg and 3.0 mm Hg respectively post-intervention (Appel, et al., 1997).

There have been multiple qualitative interview studies that reveal important findings about the perceptions of diet and its influence on hypertension among low-income women living in the southeastern U. S. These studies utilized focus groups with African American women and explored their knowledge, attitudes, behavior, and beliefs about hypertension. Participants reported that physician-recommended treatments were difficult to follow within the context of their family life and social situations (Horowitz, Tuzzio, Rojas, Monteith, & Sisk, 2004; Sharpe & Mezoff, 1995). They felt great pride in cooking and baking, especially during the holidays, for their family, friends, and church events; thus, they experienced difficulty adhering to diets because of the social meanings with food (Sharpe & Mezoff, 1995). They believed the prescribed diets were expensive and different from their traditional diets, made them feel socially isolated, and were ineffective because medications remained necessary.

The relationship between exercise and high blood pressure was assessed in previous quantitative studies (Ainsworth, Keenan, Strogatz, Garrett, & James, 1991; Gibbons, Blair,

Cooper, & Smith, 1983; Whelton, Chin, Xin, & He, 2002). Sedentary behavior was associated with a 31% increase in hypertension prevalence among African American women (Ainsworth, et al., 1991). Physical fitness was significantly associated with a decrease in blood pressure (Gibbons, et al., 1983). In a literature review of 54 randomized controlled trials, aerobic exercise was associated with a significant reduction in mean systolic and diastolic blood pressure 3.84 mm Hg and 2.58 mm Hg respectively (Whelton, et al., 2002). A reduction in blood pressure was associated with aerobic exercise in both hypertensive and normotensive (those with normal blood pressure) participants, and in both overweight and normal weight participants. Exercise was reported as an important aspect in the prevention and treatment of hypertension.

Exercise was combined with diet to reduce blood pressure among hypertensive patients in various lifestyle management programs (Englert, Diehl, Greenlaw, Willich, & Aldana, 2007; Govil, Weidner, Merritt-Wordert, & Ornish, 2009; Stevens et al., 2001). After the intervention or program, the combination of diet and exercise was associated with lower blood pressure readings. Obese patients who consumed a DASH diet combined with exercise reduced systolic and diastolic blood pressure by 12.5 mm Hg and 7.9 mm Hg respectively (Bacon, Sherwood, Hinderliter, & Blumenthal, 2004). Older adults participating in a community-based walking program showed a decrease in blood pressure after a six week follow-up (L.-L. Lee, Arthur, & Avis, 2007). These studies were successful in including multiple behavioral change strategies such as diet and exercise in lowering patients' blood pressure.

The relationship between access to care and uncontrolled hypertension was measured in previous studies (Ahluwalia, McNagny, & Rask, 1997; Ayanian, Zaslavsky, Weissman, Schneider, & Ginsburg, 2003; Shea, Misra, Ehrlich, Field, & Francis, 1992). Uninsured adults were 1.93 times significantly more likely than insured adults to be unaware of their hypertension



status (Ayanian, et al., 2003). Adults without recent contact with a health professional were 4.76 times more likely to have undiagnosed hypertension. Having a regular source of care (OR=7.93, 95% CI 3.86 - 16.29), having been to a physician in the last six months (OR 4.81, 95% CI 1.14 – 20.31), and health insurance coverage (OR = 2.15, 95% CI 1.02 - 4.52) were associated with controlled hypertension (Ahluwalia, et al., 1997). Furthermore, uncontrolled hypertension cases were reported among insured, older adults.

#### *Summary of Studies on Nutrition, Physical Activity, and Access to Care*

These studies demonstrate the successful short term improvements in blood pressure associated with diet and exercise post intervention. Disease management programs with combined diet and exercise changes were successful in lowering the blood pressure of participants. One weakness of these interventions is whether the participants are able to maintain these changes long-term after the study if they lack motivation to sustain these dietary and exercise changes. Previous studies demonstrated the importance of health insurance coverage on managing and treating hypertension. However, participants' willingness to improve their diet and physical activity and obtain access to health care may possibly be influenced by other factors not assessed in these studies such as social support from family and friends, environmental conditions, and other lived experiences. Qualitative research may provide insight into the lived experiences, perceptions, and cognitions of hypertensive patients, and eventually a deeper understanding of the barriers and the facilitators to controlling high blood pressure.

Table 9

*Summary of Literature on Nutrition, Exercise, and Access to Care*

Authors & Date	Purpose	Sample & Race	Etiological/Non-experimental	Results
Ainsworth et al., 1991	To determine the relationship between exercise and HTN	African American men and women	Cross-sectional	Sedentary behavior was associated in 31% increase in HTN prevalence in African American women
Bacon et al., 1994	To review the literature assessing BP change after DASH diet and exercise intervention	HTN adults	Literature review article	Combination of diet and exercise lowered BP post intervention
Lee et al., 2007	To assess BP among older adults after a community based walking program	Adults aged 60 and above	Randomized controlled trial	At follow-up, intervention group reported lower BP and higher self-efficacy to exercise
Hyman & Pavlik, 2001	To assess the role of access to care and HTN control	NHANES data, adult Whites, African Americans, Hispanics aged 25+	Cross-sectional	Lowest HTN control rate among adults aged 65+ and highest rate of treatment but uncontrolled HTN in African Americans
Ahluwalia et al., 1997	To identify correlates of HTN in a minority sample	HTN minority patients in HTN clinic	Cross-sectional	Having regular source of care, having been to a physician in last 6 months, health insurance coverage associated with HTN control

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Authors & Date	Purpose	Sample & Race	Etiological/Non-experimental	Results
Horowitz et al., 2004	To assess behaviors, knowledge, attitudes, beliefs on HTN	Urban African Americans and Latinos	qualitative, focus groups	Clinician recommended diets difficult to follow in social and family lives. Diets are expensive, socially isolating, and not effective enough to stop medications.

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### *Psychosocial Factors*

After an extensive review, the following variables were found to be associated with hypertension: stress, depression, and social support. Of these three, stress was the primary variable tested in the majority of previous studies in the hypertension literature. However, stress was measured in a variety of settings, age range of participants, and range of measures and variables. These include: job strain, unemployment, anger-in, anger-out, defensiveness, hostility, perceived racism, and discrimination (Table 10).

Relevant psychosocial factors were identified by patients with hypertension in the nursing literature (Table 17) (Boutain, 2001; Boutin-Foster, et al., 2007; dela Cruz & Galang, 2008; Lukoschek, 2003; Rose, Kim, Dennison, & Hill, 2000; Webb & Gonzalez, 2006b). The majority of studies recruited participants who were Black women residing in the southeast and utilized focus groups or in-depth semi-structured interviews as data collection methods. These authors utilized qualitative methods to understand how African American women perceive hypertension, how they reduce their risk factors such as diet, exercise, and stress management, and understand social contexts (Boutin-Foster, et al., 2007; Rose, et al., 2000; Webb & Gonzalez, 2006a). Also identified is the influence of the circle of culture in which African Americans report hypertension being passed down from generation to generation (R. M. Peters, Aroian, & Flack, 2006). Participants mentioned the increased worry and stress levels in their daily lives as influencing their hypertension (Boutain, 2001). Personal experiences with healthcare providers in the past influenced their perceptions of hypertension and their motivation to change their lifestyle. These studies demonstrate an in-depth understanding of participants' experiences living with hypertension and how these experiences shape their perception of hypertension management and control.

### *John Henryism*

The John Henryism (JH) hypothesis states that African Americans struggle to achieve a successful lifestyle within the context of lower socioeconomic status that may lead to poorer health status (James, 1994). The name originated from John Henry of U. S. folklore and a participant of one of James' studies. In folklore, John Henry was the African American steeldriver who faced seemingly insurmountable odds, but refused to be deterred in his aspirations; in James' study, the participant demonstrated the same behavior as in folklore. However, this active coping behavior referred to as JH in the context of severe constraints such as low socioeconomic status, job strain, unemployment, and discrimination takes its toll in the form of poor health and an early death. In a series of studies, James found that African Americans who demonstrate this tenacious and active coping style have high blood pressure and higher hypertension prevalence than Whites if they have fewer resources to achieve their goals (James, Keenan, Strogatz, Browning, & Garrett, 1992; James, Strogatz, Wing, & Ramsey, 1987).

In a series of studies, many variables including gender, socioeconomic status (SES), and social support were tested as psychosocial risk factors to elicit an active coping response (JH) and associated with hypertension levels (Dressler, Bindon, & Neggers, 1998; James, et al., 1992; James, et al., 1987; Strogatz et al., 1997; Strogatz & James, 1986). Dressler et al. (1998) examined the interaction between gender and JH in relationship to arterial blood pressure in an African American population in a Southern U.S. The interaction was significant in relation to systolic BP and HTN. For men as JH increases, BP and HTN risk also increases. For women, as JH increases, BP and HTN risk decreases (Dressler, et al., 1998). James et al. (1987) examined the influence of SES and JH on risk for elevated BP in an adult White and African American community in North Carolina. The results demonstrated that at high levels of JH, African

Americans with low SES were three times as likely to have HTN as high SES African Americans (James, et al., 1987). James et al. (1992) examined the joint influence of SES and JH on blood pressure in an adult African American sample in North Carolina. James et al. (1992) found a significant inverse association between socioeconomic status and systolic blood pressure, but not diastolic pressure. For those reporting higher in John Henryism, hypertension prevalence declined with a higher level of SES. Both of the James studies exhibit similar limitations: inability to extrapolate to the general population because the sample is limited in Pitt County in North Carolina and the social desirability response bias with questionnaire and face-to-face interview.

Stressors have been identified as major contributors to increased blood pressure. In previous studies, the following variables were associated with stress and hypertension: lack of resources, low socioeconomic status, poor housing conditions, difficulty with adherence to diet changes or restrictions, responsibilities to one's family and community, difficulty in communicating with a physician, and perceived racism and discrimination at work and in the healthcare settings (Boutain, 2001; Boutain & Spigner, 2008; Brondolo et al., 2008; Lukoschek, 2003; Rose, et al., 2000). These different variables causing stress will be discussed in detail below by summarizing previous studies.

Psychosocial variables of job strain, job decision latitude, and unemployment have also been associated with hypertension in previous studies (Curtis, et al., 1997; Levenstein, Smith, & Kaplan, 2001; Schnall, Schwartz, Landsbergis, Warren, & Pickering, 1998). According to Curtis et al. (1997), job strain is defined as exposure to high job demands, while job decision latitude is defined as authority over job decisions and amount of skill level. Levenstein et al. (2001) reported that low occupational prestige and job worries are associated with incident

hypertension. On the other hand, job insecurity, unemployment, low self-reported job performance predicted hypertension in men; low work status predicted hypertension in women (Levenstein, et al., 2001). Highly significant effects of job strain were found to influence on blood pressure in a longitudinal study (Schnall, et al., 1998). Longitudinal analysis showed that those with a high strain job at Time 1 but not Time 2 had a significant decrease of ambulatory BP at work and at home ambulatory blood pressure. Those without job strain had the lowest average ambulatory blood pressure at both times, while those with the highest chronic job strain had higher ambulatory blood pressure at both times (Schnall, et al., 1998). Also, a 3<sup>rd</sup> time point should be included to determine if the BP changes were due to the study or by random error.

In contrast, job strain failed to significantly predict hypertension (Curtis, et al., 1997). For men, high decision latitude predicted lower blood pressure; for women, high job strain was associated with hypertension. However, this study measuring job stress failed to consider confounding variables such as personal issues of the participants, social support at work, salary differences, and balancing work with domestic duties.

#### *Racism and Discrimination*

Similarly, perceived racism and discrimination have also been associated with hypertension (Brondolo, et al., 2008; Krieger & Sidney, 1996; Roberts, Vines, Kaufman, & James, 2008b; Steffen, McNeilly, Anderson, & Sherwood, 2003). Racism has been defined as the “beliefs, attitudes, and institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation” (Brondolo, et al., 2008). Discrimination has been defined as the “behavioral enactment of prejudice, which can be defined as a negative attitude towards a person or groups based on social comparisons” (Roberts et al., 2008).

The association between perceived discrimination and racism respectively with hypertension was studied among African American men and women (Brondolo, et al., 2008; Roberts, Vines, Kaufman, & James, 2008a). Other confounding factors like family life or forms of discrimination not measured may increase women's blood pressure. However, the small sample and the study setting in Pitt County, N. C., a racially segregated neighborhood where self-reported discrimination takes place are limitations of Roberts et al.'s (2008b) study.

Brondolo (2008) investigated the association of perceived racism to waking and nocturnal ambulatory blood pressure (ABP) in Blacks and Latinos. Waking ABP was defined as BP during the day and nocturnal ABP was defined as BP sleeping at night. The results showed that perceived racism was significantly associated with nocturnal SBP when controlling for personality factors and SES. Perceived racism was not significantly associated with waking ABP. The results suggest that racism may influence CVD risk during nocturnal BP recovery. Steffen (2003) examined whether perceived racism was related to change of ABP and if anger inhibition, defined as suppressing anger within oneself, contributed to this relationship. For waking BP, higher levels of perceived racism were related to an increase in SBP. Perceived racism was positively correlated to anger inhibition; anger inhibition was not associated with waking SBP or DBP.

Similarly, Krieger and Sidney (1996) assessed the relationship between self-reported experiences of racial discrimination and blood pressure and the contribution of racial discrimination to explain disparities in hypertension among Whites and African Americans. Working-class African American women had a SBP of 4 mm Hg higher among those who responded that they typically responded to unfair treatment by keeping it to themselves as a fact of life as compared to those who talked about their unfair treatment to others. Among working-



class African American men, SBP was 4 mm Hg higher among those reporting that they accepted unfair treatment as a fact of life and but talked to others about it than among those who tried to do something and talked to others.

#### *Neighborhood and Environmental Stressors*

Another dimension of stress explored in the hypertension literature is the concept of environmental stressors in the neighborhood (Agyemang et al., 2007; Cozier et al., 2007; E. Harburg et al., 1973). Agyemang et al. found that high density housing and nuisance were associated with a higher SBP and high quality of green space was associated with a lower DBP. Also, a high level of crime and nuisance from motor traffic was associated with a higher DBP (Agyemang, et al., 2007).

Furthermore, Harburg et al. (1973) examined the socio-environmental differences between Blacks and Whites from Detroit in relation to blood pressure. However, blood pressure did not vary with socio-ecological niches or a combination of gender, race, or residence. African American, younger, and overweight males with high stress levels had a significantly higher BP than African American males with low stress levels. Like Agyemang et al.'s study, these results are not generalizable since the sample is limited to a specific neighborhood in Detroit.

Next, these following variables in previous studies measuring stress consistently demonstrated strong associations with increased hypertension levels: anger-in, anger-out, defensiveness, and hostility.

#### *Anger-In*

Anger-in is defined as withdrawing from people, pouting or sulking, and becoming angrier than willing to admit. Anger-out is defined as slamming doors, saying nasty things, making sarcastic remarks to others, or arguing with others. Anger-in and anger-out were strongly

associated with hypertension levels in the psychology literature (R. Clark, Adams, & Clark, 2001; Davidson, MacGregor, Stuhr, Dixon, & MacLean, 2000; Everson, Goldberg, Kaplan, Julkunen, & Salonen, 1998; E. Harburg, Gleiberman, Russell, & Cooper, 1991; Hogan & Linden, 2004). Davidson et al. (2000) tested the association between constructive angry verbal behavior (CAB-V) and lower resting blood pressure. The results of the cross-sectional study showed that CAB-V was negatively and significantly associated with resting SBP and CAB-V was not significantly associated with resting DBP.

In addition, Harburg et al. (1991) reported that anger-out is a significant predictor of SBP and DBP in older White and African American males. For older African Americans, higher anger-out and higher education are predictors of higher blood pressure. For older Whites, anger-out was the main predictor of higher blood pressure. However, Harburg et al. found that anger-in had no significant relationship to blood pressure. Limitations of Harburg et al.'s study include the measurement of blood pressure at the end of administering the interview, difficulty of inducing anger-in situations, and individuals responding differently to anger-in situations and behaving differently toward different people. Everson et al. (1998) examined the relationship between anger expression style and hypertension incidence in a population sample of middle aged men. Each one point increase in Anger-out and Anger-in scales was associated with a 12% increased hypertension risk after a four year follow-up.

### *Defensiveness and Hostility*

Defensiveness and hostility have been found to be associated with hypertension (Fang & Myers, 2001; Nyklacek, Vingerhoets, Van Heck, & Van Limpt, 1998; Player, King, Mainous, & Geesey, 2007; Rutledge & Linden, 2000). Nyklacek et al. examined the impact of high repression or defensiveness on life events and daily hassles and resting blood pressure compared

to low repression or defensiveness. The results showed, after controlling for confounders, an inverse association between defensiveness and resting SBP and a positive association between defensiveness and resting SBP. Player et al. (2007) aimed to explore the influence of trait anger and long-term psychological stress on the progression to hypertension and the incidence of coronary heart disease in pre-hypertensive men and women. Their results showed high long term stress and high hostility were positively associated with hypertension progression (Player, et al., 2007). Rutledge and Linden (2000) examined the value of defensiveness as an indicator for the development of clinical hypertension. The results demonstrated that high defensiveness was an indicator for hypertension; logistic regression analyses showed that high defensiveness was associated with more than a seven-fold risk of hypertension in three years. Similarly, Fang and Myers (2001) investigated the effects of race-related stressors and hostility on cardiovascular reactivity in white and Black college students. The results showed that high hostility was associated with higher recovery SBP and DBP levels after exposure to the films. Indirect exposure to interpersonal conflict or seeing it elicits a significant reactivity after exposure to the stressor.

### *Depression and Social Support*

In addition to stress, other psychosocial factors associated with hypertension are depression and a lack of social support (Bosworth, et al., 2003; Strogatz, et al., 1997; Strogatz & James, 1986). Bosworth et al. (2003) found that minorities who were depressed with low subjective support and cardiovascular co-morbidities were more likely to be hypertensive than non-depressed at baseline. However, hypertension was self-reported and blood pressure measurements or a physician diagnosis were not reported.

Social support generally was measured in two forms: instrumental support and emotional support. Strogatz and James (1986) provided definitions for social, instrumental, and emotional support. Social support was defined as comfort, assistance, and information a person perceives through formal or informal contacts with individuals or groups. However, social support also contains a dimension of instrumental support, defined as dealing with tangible problems and the likelihood of getting help. Example of questions include “If you needed help around the house (e.g. like cleaning or making small repairs), could you get someone to help without pay?”, “If you could not use your car or your usual way of getting around for a week, could you find someone who would take you wherever you needed to go?”, and “If you needed to borrow a fairly large sum of money, do you have someone or somewhere (e.g. a bank) you could borrow it from?” Emotional support may be defined as the availability of advice, for example measured as “If you are worried about an important personal matter, is there someone you can go to?”

In addition, Strogatz and James (1986) examined the association between social support and hypertension prevalence among Blacks and Whites. The authors reported African Americans were more likely to have both kinds of social support. Low instrumental support was more associated with hypertension prevalence in African Americans earning less than \$10,000 than compared to Whites. Hypertension prevalence by race was equal across levels of emotional support. Similarly, Strogatz et al. (1997) also conducted another study in Pitt County, North Carolina assessing the association between perceived stress and social support with blood pressure. Their results showed that, for women, emotional and instrumental support were negatively correlated with systolic and diastolic blood pressure. For men, emotional support negatively correlated and instrumental support positively correlated with blood pressure. Stress and emotional support were more strongly associated with diastolic blood pressure.

*Summary of Studies Testing Hypertension Risk Factors and Related Variables*

These studies reveal significant associations and correlations between several variables and high blood pressure. The strongest relationships were found with the variable of stress which was measured in a variety of forms in the literature such as John Henryism, job strain, racism, discrimination, anger in and out, defensiveness, and hostility. While knowledge of these statistical relationships is important, these authors do not describe the participants' daily experiences with living with hypertension. These quantitative studies do not take into account the possible influence of external experiences on their HTN management and control such as employment status, family, and financial difficulties. This qualitative knowledge of patient experiences can illuminate our understanding of hypertension and those patients currently managing their blood pressure.

Table 10

*Summary of Stress-Related Studies Utilizing Quantitative Methods*

Authors & Date	Purpose	Sample, Race/ethnicity	Design	Summary of findings
Player et al., 2007.	To explore the influence of trait anger and long-term psychological stress on progression to HTN and incident CHD in persons with pre HTN	men and women 45-64 Black, non-Black	prospective cohort, cross-sectional	High long term stress and high hostility were positively associated with HTN progression in men and women
Brondolo et al. (2008)	To investigate the relationship of perceived racism to both waking and nocturnal ambulatory BP in AA and Latinos	24-65 AA and Latinos American born and English speaking,	cross sectional	1.Perceived racism sig associated with nocturnal SBP and DBP but not daytime ABP.
Davidson et al., 2000	To test whether constructive anger expression is associated with healthier or lower resting BP in a population based sample.	Canadian adults aged 18+	cross sectional	CAB-V neg and sig for resting SBP and neg not sig for resting DBP.
Steffen et al. 2003	1. To examine whether perceived racism was associated with BP. 2. To evaluate whether anger inhibition contributes to this relationship.	employed African American men and women with normal or elevated BP	cross sectional	1. For waking BP, higher levels of perceived racism related to increased SBP. 2. Perceived racism positively correlated with anger inhibition. 3. Anger inhibition not related to waking SBP or SBP.

Authors & Date	Purpose	Sample characteristics	Design	Summary of findings
Schnall et al. 1998	To investigate the hypothesis that exposure to job strain is related to increased ambulatory BP (ABP)	male workers aged 30-60	cross sectional	Significant association between high job strain and increase in blood pressure
Rutledge & Linden, 2000	To examine the value of defensiveness as a prognostic indicator for the development of clinical HTN	white and Asian college students and adults in Canada	prospective cohort	High defensiveness was associated with more than 7 fold risk of 3 year HTN.

Table 11

*Summary of Stress-Related Studies Utilizing Qualitative Methods*

Authors & Date	Purpose	Sample & Race	Design & Method	Summary of findings
Boutin-Foster et al., 2007	To identify the personal, social, environmental factors that might influence their perceptions	Purposive sample, African American patients with uncontrolled HTN in a primary care practice	Qualitative - In depth structured interviews	Factors shaped HTN: experiences of social networks, personal experience with HTN, influence of medical literature, provider-patient encounters
Lukoschek, 2003	To explore different beliefs commonly held by adherent and nonadherent patients	uninsured or Medicaid low SES minorities with low education levels	Qualitative comparative case-focus groups	HTN caused by emotional triggers. Stressors increase BP: city, family life, housing, SES, physician's visit, perceived racism
Rose et al., 2000	To understand Black males experiences living with HBP	Inner city AA males 33-49, subset currently enrolled in ongoing clinical trial	Qualitative - descriptive exploratory (In depth structured interviews)	Importance of personality in managing HBP, difficulty seeking help and support, expressing health concerns to others, difficulty accepting concerns from others, social difficulties -unemployment, low paying jobs, having HBP was inevitable
Webb & Gonzales, 2006.	To explore AA women's mental representations of HTN	AA women in metropolitan southeast city	Qualitative- focus groups	1. Vulnerability and inevitability (hereditary, living in poverty) 2. behavioral (stress- most sig risk factor at work, being AA, family, community - being super person) 3. Barriers to effective management (daily hassles, low income, perceived racism with physicians)



### *Blood Pressure Monitoring*

The measurement of blood pressure as an outcome variable varies widely across the majority of studies. Methods used to report blood pressure include self-report, measurements prior to completing a survey, measurements while completing a survey or interview, or what is found in patient medical records. The participants' blood pressure may increase by mere participation in the study or reacting in haste to the researcher or interviewer. Furthermore, the term blood pressure was defined differently among the studies. These include systolic blood pressure (SBP), diastolic blood pressure (DBP), both SBP and DBP, hypertension incidence, hypertension prevalence, and mean blood pressure levels (Brondolo, et al., 2008; Davidson, et al., 2000; Fang & Myers, 2001; E. Harburg, et al., 1991; James, et al., 1992; James, et al., 1987; Levenstein, et al., 2001; Steffen, et al., 2003). The most accurate measure common in recent studies is ambulatory blood pressure, in which a device is connected to a participant's arm that regularly takes measurements at pre-determined intervals for prolonged periods (Fang & Myers, 2001; Schnall, et al., 1998; Steffen, et al., 2003). The ambulatory device can be tracked by researchers at a separate location and the measurements demonstrated strength in reliability and validity (Schnall, et al., 1998; Steffen, et al., 2003).

Home blood pressure monitoring (HBPM) is another promising tool but with inconsistent results in terms of HTN control (Bosworth et al., 2007; Cooper, 2009; Goulis et al., 2004; Green et al., 2008; Kerry et al., 2008; Parati et al., 2009; Pickering, 2008; Qureshi, Saliccioli, Clark, & Lazar, 2008; G. Stergiou & Parati, 2009; G. S. Stergiou, Rarra, & Yiannes, 2009; Terschuren, Fendrich, van den Berg, & Hoffmann, 2007; Yealin, de Greeff, & Shennan, 2009). HBPM is used by nurses or pharmacists to access a patient's periodic BP readings at an automated center while a patient wore the monitoring device at home during an intervention. Some studies

produced decreases in BP and improved compliance, while others produced no significant differences in BP levels post intervention. Thus, the continuous measure of BP at work and home presents a more accurate measurement than a single BP measure in a clinical setting (Table 12).

Table 12

*Summary of Blood Pressure Measurement Studies*

Authors & Date	Purpose	Method of blood pressure measurement	Sample	Design	Results
Stockwell et al. 1994	Identify determinants of awareness, treatment, control of HTN in workers	Before completion of survey or self-report	White adult health care employees	Cross sectional	Days of HTN medication was significantly associated with HTN treatment and control
Greenberg et al. 2006	Identify determinants severe, uncontrolled HTN in Veterans	patient medical records	White and AA Veterans	Cross sectional	Age, race, education, comorbidities, alcohol abuse, number of HTN medications were predictive of HTN
Clark et al. 2001	To examine the relationship between John Henryism, anger, and blood pressure changes	before completion of survey	AA female college and graduate students	Cross sectional	JH was positively related to blood pressure changes
Ainsworth et al. 1991	To determine association between physical activity and HTN	during completion of survey	AA adults 25-50	Cross sectional	Sedentary activity not associated with HTN prevalence in men but was associated with a strong increase in HTN prevalence in women

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Authors & Date	Purpose	Method of Blood Pressure Measurement	Sample	Design	Results
Parati et al. 2009	To determine differences in blood pressure between HBPM and clinic measurements	Home blood pressure monitoring	White adults	randomized controlled trial	BP decreases more after HBPM versus a clinic measurement
Bosworth et al. 2003	To examine the relationship between depression and HTN	Self-report	White older adults	Prospective cohort	HTN patients more likely to be depressed

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### *Summary of Studies on Blood Pressure Monitoring*

Overall, the reviewed blood pressure monitoring studies report mixed results. Blood pressure measurement in a clinical setting may not be representative of a patient's ongoing blood pressure. However, HBPM offers promising results for clinicians and patients. Although HBPM measures BP at work and at home throughout the day, the potential barriers and the patient's motivation to lower blood pressure were not assessed in previous studies. Knowledge of a patient's lived experiences with hypertension may provide insight into potential barriers and motivation to lower blood pressure. Qualitative research can articulate the perspectives of patients currently living with hypertension and address the situational contexts of a patient's daily activities which cannot be assessed in a blood pressure measurement done in a clinic setting or by HBPM.

### *Noncompliance with Hypertension Treatment*

A review of the hypertension literature revealed promising results and strategies regarding noncompliance with treatment (Table 13). These commonly found topics are addressed: patient and family education, disease management programs and interventions, health care provider and patient surveys, and qualitative and motivational interviewing with patients.

First, conducting patient education and disease management programs are important steps toward improved compliance (Morisky, Kominski, Afifi, & Kotlerman, 2009; Roumie et al., 2006; Saounatsou et al., 2001). In these programs, nurses educated patients on a healthy lifestyle and provided individual counseling. Previous studies found that at post test intervals BP decreased to normal levels and patients improved compliance with education (Morisky, et al., 2009; Saounatsou, et al., 2001). These reviewed studies demonstrate the success of patient education and chronic disease management programs for improving compliance among HTN

patients.

Second, surveying health care providers and patients to measure their attitudes is an important step toward improving compliance in the future (Dean, Kerry, Cappuccio, & Oakeshott, 2007; Holland et al., 2008b; R. M. Peters, Benkert, Butler, & Brunelle, 2007; Pilkington, 1999; van Wissen, Litchfield, & Maling, 1998). In a previous study, patients were surveyed to measure their attitudes on the knowledge of hypertension, compliance, and lifestyle changes. Results revealed significant differences between social support and compliance (Dean, et al., 2007; Pilkington, 1999). In a study investigating compliance, private healthcare providers were surveyed on their attitudes toward noncompliance and adherence to JNC 7 guidelines, however no significant differences were found between patient compliance and provider adherence to the JNC 7 guidelines (R. M. Peters, et al., 2007). Barriers were identified to assist in the design of patient education and disease management programs.

Motivational interviewing is a promising tool to assist health care providers, health educators, and researchers in progressing toward improved compliance (Jefferson, 2008; Knight, McGowan, Dickens, & Bundy, 2006; Marquardt & Vezeau, 2007; G. Ogedegbe et al., 2008; Gbenga Ogedegbe et al., 2007). Motivational interviewing (MI) is defined as:

“An evidence-based practical, patient-centered counseling approach of augmenting an individual’s motivation to change problem behaviors. It is a directive, client-centered counseling style that seeks to help clients explore and resolve ambivalence about behavior change. It is described as the polar opposite of advice giving and sets out to identify how ready, willing, and able a person is to change and counsel them accordingly” (Knight, et al., 2006, pp. 319-320).

The results of studies utilizing motivational interviewing (MI) with non-compliant

patients are promising. Designs included patient education with MI, testing of significant differences between the MI and non-MI groups, and the randomization of treatment, and use of a control group without motivational interviewing. Knight et al. (2006) reviewed eight studies utilizing MI in an intervention setting. Studies utilizing a randomized controlled trial (RCT) reported a lowered blood pressure after follow-up and increased probability to lower blood pressure (Knight, et al., 2006; G. Ogedegbe, et al., 2008). Results have shown a significant blood pressure decrease for older adults with HTN in a motivational interviewing group compared to a phone contact and control group (Woollard et al., 1995).

#### *Summary of Studies on Noncompliance for Treatment of Hypertension*

These previous studies offer promising strategies to health care providers in terms of reducing noncompliance among hypertensive patients. Weaknesses of these studies include the lack of a qualitative evaluation component of these interventions and the pilot testing of the interview protocol. Also, the mentioned qualitative studies did not make comparisons by gender and race and did not utilize a theoretical framework to design the studies. Qualitative research methods can be helpful in evaluating a hypertension program by interviewing the patients in the program about their experiences living with high blood pressure. Through utilizing qualitative interviewing, health care providers and public health professionals can gain insight into the lived experiences of patients which can assist in reducing future noncompliance.

Table 13

*Summary of Noncompliance with Hypertension Studies*

Authors & Date	Purpose	Methods	Sample	Design	Summary of findings
Roumie et al. 2006	To evaluate patient and provider interventions on blood pressure control	intervention: patient education, provider education with and without alert	Veterans hospital patients	randomized controlled trial	Patients in patient education group has lowest BP than provider education alone or control groups
Dean et al. 2007	To examine barriers for poor BP control	patient and provider surveys	HTN patients aged 50-80	cross-sectional	Few patients knew target BP.
Lukoschek, 2003	To explore beliefs of adherent and nonadherent patients to identify beliefs that prevent adherence to therapy	focus groups	African American adult HTN patients	qualitative	Health beliefs on HTN, medications, and physician relationship influenced their decision to take medications.
Woollard et al., 1995	Test change in BP after motivational interviewing intervention	3 groups: Motivational interviewing (MI), phone contact, control	older adult HTN patients	controlled trial	Significant BP decrease for MI intervention groups versus non-MI groups



*Health Behavior Theories*

Before addressing the qualitative methodology as stated in Chapter Three, it is important to address the health behavior theories which can provide a solid foundation for the conceptual framework of phenomenology. The Health Belief Model (HBM) is one of the most widely recognized theories in health behavior research for five decades. Social psychologists in the U. S. Public Health Service initially developed HBM to explain the widespread failure of people to participate in disease prevention and detection programs (Hochbaum, 1958; Rosenstock, 1960, 1974). One example is the failure of large numbers of eligible adults to participate in free tuberculosis screening programs in mobile X-ray units located in various neighborhoods. Hochbaum (1958) surveyed samples of adults to understand their readiness to obtain X rays which included their beliefs that they were susceptible to tuberculosis and their beliefs in the personal beliefs of early detection. Among those with belief in their susceptibility to tuberculosis and the belief in overall benefits of early detection, 82 percent had at least one chest X ray during the period. Of those with neither of these beliefs, only 21 percent had X rays during the period. After Hochbaum's study several authors, expanded HBM to apply to preventive, illness, and sick-role behaviors (Becker, 1974; Janz & Becker, 1984; Kirscht, 1974).

HBM addresses an individual's perceptions of the threat posed by the health problem (perceived severity and susceptibility), benefits of avoiding the threat, and the factors influencing the decision to act (perceived barriers, cues to action, and self-efficacy). Since health motivation is its central focus, HBM is a good fit for addressing problem behaviors that evoke health concerns. When applying HBM to planning health programs, public health practitioners should seek to gain an understanding of how susceptible the target population feels to the health problem, whether they believe it is serious, and whether they believe action can reduce the threat

at an acceptable cost (Glanz, Rimer, & Lewis, 2005).

HBM constructs have been associated with hypertension in previous studies (C. M. Brown & R. Segal, 1996; Coverson, 2006; Cronin, 1986; DeWitty, 2007; King, 1983). Participants' perceptions of hypertension and their health behaviors were assessed in surveys (King, 1983; Newell, 2008). Authors reported that HBM constructs were associated with noncompliance and medication non-adherence (Cronin, 1986; Hershey, Morton, Davis, & Reichgott, 1980). African Americans reported low perceived susceptibility to HTN and believed less in the perceived benefits of prescribed medications versus home remedies (Ali, 2002; C. M. Brown & R. Segal, 1996).

### *Self-efficacy*

Self-efficacy is defined as the conviction that an individual can successfully execute the behavior required to produce the outcomes (Bandura, 1977). Self-efficacy has also been defined as the confidence in one's ability to perform an activity, also the confidence to overcome barriers of performing a behavior take action to change a behavior (Glanz, et al., 2005). Bandura (1977) stated self-efficacy is the most important pre-requisite for behavior change because it affects how much effort is invested in a given task and what level of performance is attained. Self-efficacy has played an important role in changing many health behaviors such as predicting success with smoking cessation and maintaining diet and exercise routines (Ewart, Taylor, Reese, & DeBusk, 1983; Jeffery et al., 1984; Parcel et al., 1995; Sheeshka, Woolcott, & Mackinnon, 1993; Strecher, McEvoy DeVellis, Becker, & Rosenstock, 1986).

From these HTN studies reviewed, self-efficacy was tested as a separate construct apart from HBM. Self-efficacy was found to be associated with hypertensive adults. Low self-efficacy is problematic for hypertensive adults with poorer health status who lack the confidence to

improve their dietary and exercise behaviors (Martin et al., 2008). High self-efficacy was associated with improvement in dietary and exercise behavior of hypertensive women (Burke, Mansour, Beilin, & Mori, 2008; Daley, Fish, Frid, & Mitchell, 2009; Folta et al., 2009). Also low self-efficacy was associated with noncompliance among hypertensive patients (Schoenthaler, Ogedegbe, & Allegrante, 2009). However, authors suggest the need to tailor self-efficacy to a patient's specific health needs and health behaviors (Finset & Gerin, 2008; Martin, et al., 2008).

#### *Theory of Reasoned Action and Planned Behavior*

TRA was first introduced in 1967 and focuses on the relationships between beliefs (behavioral and normative), attitudes, intentions, and behavior. The TRA was developed with the aim to understand the relationship between attitude and behavior (Fishbein, 1967). It was reported that attitude toward a behavior is a more accurate predictor of a behavior than the attitude towards a target or disease (Fishbein & Ajzen, 1975). A related example is that one's attitude toward hypertension is expected to be a poor predictor of blood pressure screening behavior, but attitude toward seeking blood pressure screening is expected to be a good predictor. Recently, TRB has been applied to various health behaviors such as exercise, smoking, drug abuse, HIV/STI prevention, mammography utilization, clinician provision of preventive services, and oral hygiene behaviors.

Theory of Reasoned Action (TRA) and Theory of Planned Behavior (TPB) focus on individual motivational factors as determinants of the likelihood of performing a specific behavior (Glanz, Rimer, & Lewis, 2002). TRA includes measures of attitude and social normative perception that determine behavioral intention, which in turn affects behavior. TPB includes an additional construct concerned with perceived control over performance of the behavior. Motivation to comply is defined as an individual's motivation to follow what the

reverent believes about the behavior (Sharma & Romas, 2008). Normative beliefs are beliefs about whether or not people approve or disapprove of the behavior (Sharma & Romas, 2008). Subjective norm is the belief about whether most people in the individual's life approve or disapprove of the behavior. Subjective norms are based on the assumption that social pressure encourages people to behave in a socially desirable manner and people are motivated to comply with these expectations (Kagee & van der Merwe, 2006).

In terms of testing the theories, few studies focused on associating the theoretical constructs of TRA and TPB with hypertension (P. Miller, Wikoff, & Hiatt, 1992; S. D. Taylor, Bagozzi, & Gaither, 2001). Compared to men, women reported higher subjective norms when controlling their blood pressure (S. D. Taylor, et al., 2001). Motivation to comply has been associated with improving diet, exercise, and stress for adults diagnosed with hypertension (P. Miller, et al., 1992). Thus, the few results suggest the need to conduct additional studies on TPB and TRA constructs as related to hypertension.

#### *Summary of Studies on Health Behavior Theories*

Overall, HBM constructs, self-efficacy, and TRA/TPB constructs were tested for their associations with hypertension in cross-sectional studies (Table 14). One major weakness of these studies is that the participants' understanding of the theoretical constructs as intended by the researchers is questionable. External factors outside of the study may have influenced the participants' responses to the survey questions relating to the theoretical constructs. The environments in which participants apply these theoretical constructs were not described and not addressed in these studies. Qualitative research is well-suited to capturing the detailed experiences and describing the situational contexts for patients living with hypertension. These methods can provide deeper insight into a participant's perspective as they answer questions on

constructs like self-efficacy, perceived barriers, and motivation to comply in terms of lowering their BP.

Table 14

*Summary of Health Behavior Theory Studies Applied to Hypertension Control*

Theory or Model	Purpose	Race of Sample	Design	Results
Health Belief Model (HBM)	Determine associations between HBM constructs and HTN	White	Cross-sectional	Low perceived susceptibility and low perceived benefits of medications versus home remedies
Self-efficacy	Determine association between self-efficacy and HTN	White	Cross-sectional	Low self-efficacy associated with poorer health status & noncompliance, high self-efficacy associated with improved diet/exercise
Theory Reasoned Action/Planned Behavior (TRA/TPB)	Determine associations between TRA/TPB constructs and HTN	White	Cross-sectional	Women reported higher subjective norms for HTN control, motivation to comply associated with improved diet/exercise and reduced stress

## *Phenomenology*

To apply these previously mentioned health behavior theoretical constructs to hypertension in my study, I will utilize phenomenology as my conceptual framework. Munhall states that “immersion is an essential and critical beginning of a phenomenological study. Phenomenological inquiry just cannot be done well or have any meaning if the researcher has not learned the language and come to understand the philosophical underpinnings of phenomenology” (Munhall, 2007). Thus, I will first discuss the concept of phenomenology in-depth before discussing the design of my qualitative study in Chapter 3.

Edmund Husserl first introduced phenomenology in the early 1900s as trying to strengthen the positivist movement. Husserl desired to restore the reality of humans in their life worlds, to capture the meaning of this, and to revive philosophy with new humanism (Husserl, 1965). He believed philosophy should become a rigorous science that would restore contact with deeper human concerns and phenomenology should become the foundation for all philosophy and science (Husserl, 1931, 1965). To recover original awareness, Husserl challenged individuals to take a fresh approach to concretely experienced phenomena themselves and be free from conceptual presuppositions. Husserl never developed a systematic philosophy, instead he was interested in laying foundations to establish a clear, secure basis for human science.

Key concepts of phenomenology to address include consciousness, embodiment, natural attitude, experience, and perception (Munhall, 1994). Consciousness is a sensory awareness of and response to the environment; it is existence in the world and through the body (Merleau-Ponty, 1962, 1964). Embodiment explains through consciousness we are aware of being-in-the-world, and it is through the body that we gain access to this world (Munhall, 1994). The natural attitude is a mode of consciousness that espouses interpreted experiences. Experience and

perception are our original modes of consciousness (Munhall, 1994). Taking place through the body, perception is an individual's access to experience in the world. Perception of experience is what matters, not what in reality may appear to be contrary or more truthful. The emphasis is placed not on what is happening, but what is perceived as happening.

Phenomenology is useful for the public health and nursing fields because it allows public health professionals and healthcare providers to gain an in depth understanding of the experiences and perceptions of health behaviors which we desire to change or improve. Phenomenology allows them to understand the emotions, cognitions, and experiences of participants and patients who are currently in the process of changing health behaviors in order to lower their risk of illness or disease. It gives audiences a deeper insight into their perspective and worldview so that we may assist them in their behavior change by providing better communication, social support, increase their motivation to change, and design behavior change programs or interventions tailored towards their needs as an individual.

Phenomenology is a concept which has been explored within nursing research (Crotty, 1996; Munhall, 1994, 2007). According to van Manen,

Phenomenology is the study of the individual's life-world – the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it. Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. Phenomenology asks, "What is this or that experience like?" (van Manen, 1990, p. 9).

The goal of phenomenology is to describe the total systematic structure of lived experience, including the meanings that these experiences had for the individuals who participated in them (Omery, 1983). In summary, phenomenological research is the "study of the essences of



experience with the aim to understand the experience” of an individual or individuals (Munhall, 2007, p. 163). Moreover, Munhall discusses phenomenology in terms of human experiences:

Phenomenological research is a quest for what it means to be human. The more deeply a person understands human experience, the more fully and uniquely he or she becomes human. Such individuals learn to notice and to make sense of the various aspects of human existence. The more often a person engages in such attentiveness, the more he or she should be able to understand the details as well as the more global dimensions of life. (p. 163)

This framework is relevant to my study because I am interested in understanding the shared lived experiences of a small sample of Whites and African Americans diagnosed with uncontrolled hypertension through in-depth dialogue and reflection. Zerwekh states that storytelling is emerging as a powerful qualitative strategy for understanding taken-for-granted practical knowledge. The perspective of phenomenology seeks to understand human experience through dialogue with ordinary people (Crotty, 1996, p.22). In summary, a phenomenological approach is the appropriate framework to answer my qualitative research questions.

### *Summary of Literature Review*

#### Summary of existing studies and gaps in the literature

The hypertension literature presents many useful quantitative findings for clinical practice and public health professionals, however common weaknesses remain which need to be addressed in the future. Previous intervention and CVD prevention programs have shown progress in identifying CVD risk factors and educating at risk communities about CVD risk factors. Health behavior theoretical constructs were found to be helpful in finding attitudes and behaviors associated with hypertension. Stress is the major factor relating to hypertension that

emerged from the literature, with strong positive associations and correlations in many forms such as defensiveness, hostility, anger in, anger out, and discrimination. Many studies in the hypertension literature were quantitative, demonstrating statistical associations between hypertension-related variables and hypertension levels. Although the findings of these statistical associations are useful, it is important to understand the experiences of older adults living with hypertension. Few qualitative studies reported rich perspectives of older adult patients living with hypertension. To address these weaknesses reported in the literature, more formative research is needed to contribute to a holistic understanding of hypertension and to create a solid foundation on which to design a tailored intervention for older hypertensive adults.

#### *Purpose and Rationale*

The purpose of the proposed study is to contribute to an in depth understanding of the phenomenon of hypertension among older White and African American adults. Furthermore, an in depth understanding of patients' common lived experiences with hypertension is necessary to assist physicians and nurses who encounter non-compliant patients and poorly controlled hypertension in clinical practice and assist in the design of future hypertension reduction interventions. A detailed description of patient experiences with diet, physical activity, daily stressors, access to health care, compliance or noncompliance with treatment, self-efficacy, perceived barriers to hypertension control, and motivation to comply with prescribed treatment is necessary to understand how common patient experiences may influence the development and may inhibit hypertension control and management. This exhaustive list of factors has not been previously described in one study in the literature, particularly for older adult men and women. Survey methods cannot obtain these detailed patient descriptions and statistical associations cannot analyze possible differences between the descriptions of Whites and African Americans.

Thus, the purpose and research questions of this current study fit the appropriate choice of qualitative methods versus quantitative methods. This proposed study can fill these gaps in the literature by contributing to an in-depth knowledge of patient experiences living with hypertension in a southeastern city and contributing to a qualitative evaluation of a state hypertension management program.

For this project, my target population is older adults age 55 and above diagnosed with hypertension and currently attending a hypertension clinic adjacent to a large southeastern university. The minimum age of 55 and above was chosen because of the sharp increase in HTN prevalence according to Tables 6 and 7 in Chapter 1 (p. 6-7). Participants at the time of the study have either controlled or uncontrolled hypertension according to their last 2 visits from their medical records and be recruited following their clinic visit. Exclusion criteria included races other than African American and White and patients not currently attending the SHAPP clinic. In order to gather rich, qualitative data, an individual semi-structured interview was conducted with each participant on their experiences living with hypertension and maintaining a healthy lifestyle. Phenomenological analysis was utilized to analyze the interview data.

### *Research Questions*

To frame this study, I pose the following questions:

1. What are the lived experiences of African American and White older adults diagnosed with hypertension?
2. What are the differences in the experiences between African Americans and Whites?
3. What are the differences in the experiences between men and women?

## CHAPTER 3

### METHODOLOGY

The literature review indicates that the field of hypertension contains few qualitative studies conducted in the public health, nursing, and medical fields. Interventions may fail to control participants' blood pressure during follow-up or after treatment without addressing the perceptions and experiences of the participants involved. Research should first be conducted to identify important lived experiences of hypertension patients to be addressed in designing culturally relevant surveys and programs aimed at lowering blood pressure rates in the future. The purpose of the study is to understand the lived experiences of older adults diagnosed with hypertension. The methodology used in this study is discussed. In this chapter, research design, conceptual framework, sampling, recruitment of participants, data collection site and procedures, data analysis methods, anticipated findings, and study limitations are described.

#### *Research Design and Rationale*

My overall research design is a descriptive qualitative study. A descriptive qualitative study describes social phenomena and contributes to a deeper understanding about them (Rossman & Rallis, 2003). I described the phenomenon of living with hypertension and contributed to an in-depth understanding of elderly adults living with hypertension. I recruited a sample of White and African American men and women aged 55 and above diagnosed with hypertension at the Athens Cardiovascular Health Clinic. My purpose is to understand the meanings of older adults' lived experiences living with hypertension. This design is the best choice for my research topic because qualitative research is better suited to capturing and representing people's lived experiences than quantitative approaches such as survey research or

experimentation common in the hypertension literature. The descriptive and in-depth nature of qualitative research matches the purpose of the study versus the statistical associations between variables common in quantitative research.

There are strengths of using a qualitative research design for addressing my research questions. First, I gained an in-depth perspective of older adults diagnosed with uncontrolled hypertension. Second, this design provided descriptive rather than statistical explanations of the psychosocial differences between Whites and African Americans with hypertension. Third, these results are useful to public health researchers and health educators in designing culturally sensitive surveys and interventions aimed at lowering hypertension among older adults. This design also guides the application of health behavior constructs like self-efficacy, perceived barriers, cues to action, and motivation to comply to create a foundation for designing culturally sensitive hypertension programs. I apply phenomenology by utilizing a design that allows for an in-depth understanding of participants' common experiences with these previously mentioned constructs as applied to hypertension control and management.

On the other hand, limitations of my study design exist which should be equally addressed as well. The limitations are similar to those of qualitative research in general. The study's results represent those of only the participants and not the nursing staff, clinic staff, district nurse, or county nurse health department manager. These include the use of purposive sampling, small sample size, lack of generalization to all African Americans and Whites in the United States, my subjectivity in the interview situation and data analysis, lack of random sampling, no randomized or experimental research design, and lack of a statistical association between variables and tests for statistical significance.

Participant bias is another limitation for the researcher to consider in this design.

Participants are from the Southeastern United States, currently enrolled in a state hypertension control clinic, and have the time to converse in an in-depth interview. They are of low-income status, low-educated, and mostly uninsured. Participants may feel the need to provide the interviewer with information which matches the purpose of the study. The participants' experiences described in the interview may not accurately depict their real life experiences since they are providing social desirable answers to the interviewer.

### *Research Questions*

As noted in Chapter 1, my research questions for this study are:

1) What are the lived experiences of White and African American older adults diagnosed with uncontrolled hypertension?

Supporting questions I asked in my interview guide are as follows:

1a. Tell me about your experiences in this clinic.

1b. Tell me how you feel you are being treated by the nurses.

1c. Tell me what your life was like when you were first diagnosed with hypertension.

1d. What has your life been like since you were first diagnosed with hypertension?

1e. Tell me how you control your blood pressure.

2) How do the lived experiences of White and African Americans diagnosed with uncontrolled hypertension differ?

3) How do the lived experiences of men and women diagnosed with uncontrolled hypertension differ?

Supporting questions I asked in my interview guide are as follows:

3a. Do worries or hassles affect how you control your blood pressure?

3b. Are there things in your life that can make your blood pressure go up?

*Conceptual Framework*

To address my research questions, I utilized a phenomenological approach as my conceptual framework for my study, as stated in Chapter 2.

*Subjectivity Statement*

In addition to identifying a phenomenological approach as the conceptual framework, I have several relevant subjectivities to acknowledge before conducting this study. One relevant subjectivity is my expectation that there are differences in the experiences of African Americans and Whites living with hypertension such as income disparities, work stressors, and noncompliance. Whites may be practicing more healthy behaviors than African Americans who may consume a poor diet, are sedentary, and live in violent neighborhoods. I may perceive African Americans as having a lower level of self-efficacy and few or no sources of social support to practice healthy behaviors and a lack of knowledge of CVD risk factors associated with HTN. I may perceive that African Americans may be noncompliant with White physicians or those of another race due to miscommunication of health beliefs and cultural differences. A second relevant subjectivity is that I currently live in Athens, Georgia and aware of the poverty levels and income disparities that exist in Athens-Clarke County, Georgia. This may influence my interactions with the participants during the interview to seek information such as living in a low-income, violent neighborhood with few sources of social support. A third relevant subjectivity is that I am not diagnosed with hypertension or other chronic health conditions. I am young in age and in currently good health with strong motivation to practice wellness behaviors. My good health and wellness behaviors may influence me to misjudge other patients who are unable to control their blood pressure and view their poor health behaviors in a condescending

manner. However, I know people with hypertension who have discussed their experiences with me and have family members with hypertension. A fourth relevant subjectivity is that I have previous experiences in healthcare settings where I witnessed patients with hypertension and other chronic health conditions. This may influence me to have preconceived notions about the health behaviors of the participants I am interviewing and judge them to be practicing unhealthy behaviors such as smoking, binge drinking, and obesity. A fifth relevant subjectivity is my limited experience with in-depth interviewing. In my volunteer and paid experience in the healthcare field, I am familiar with the structured medical interview between the health care provider and patient which may influence the manner in which I conduct these interviews towards a more short question and short answer format. I have minimal in-depth interviewing experiences with my qualitative courses in my doctoral program. Continuing to conduct semi-structured interviews in this study will improve my interviewing skills. A sixth relevant subjectivity is my undergraduate background in psychology and strong interest in learning about cognitions and changing behaviors. I have a deep curiosity for learning about individual's experiences and struggles with behavior change for the last nine years. I am interested in learning about health behaviors of older adults, specifically African Americans. A seventh relevant subjectivity is my background of six years of quantitative research prior to enrolling in qualitative research courses. This training may influence me to utilize statistical terminology in my research writing.

In addition to researcher subjectivities, I have roles as an insider and outsider in the research setting. One role as an insider is that I have been reading articles about hypertension and studies on reducing hypertension statistics for the last four years. During my Master of Public Health program I wrote research papers on designing a hypertension program plan and published



a paper on a hypertension needs assessment. Second, I possess strong interests in reducing racial health disparities for chronic diseases, especially for minorities and women.

On the other hand, I should address the outsider dimensions in my role as the researcher. First as an outsider, I am a doctoral student from a research university conducting interviews in a state public health clinic in close proximity to my university. Second, I may be an outsider because I may appear more articulate and of a different race than those who I am interviewing. Also I am not affiliated with the clinic and do not have relatives or friends attending or working at the clinic. I am entering a clinic attempting to interview strangers about their experiences living with hypertension, which may be a personal and sensitive topic to discuss. Third, I am Asian American and unable to identify with White and African American patients in terms of their culture and race. Fourth, I have been studying public health classes over the last five years and health promotion courses the last three years and may be more educated and more closely aware of health behaviors and changing unhealthy behaviors than the participants whom I am interviewing.

### *Bracketing*

Now that my subjectivities and inside and outsider roles are stated, it is important to address these subjectivities by bracketing. In order to collect and analyze data without bias, I should use bracketing as I address my subjectivities as the researcher. Although researchers may intend to obtain subjective data from the participants while maintaining objectivity throughout analysis, they also come with prior knowledge, beliefs, judgments, preconceived ideas and theories, or personal and theoretic biases (Crotty, 1996). I believe using bracketing will be beneficial to me during the data collection and analysis process. Crotty (1996) states:

Bracketing makes it possible for researchers to focus on the participants' experience.

While allowing informants to construct and give meaning to their own reality, it enables

researchers to gain entry into the conceptual world of those informants and discern it

fully. In this way, the data are accepted uncritically as given. They are not tainted. (p. 19)

Through bracketing, I will not allow my preconceived beliefs and assumptions about hypertension to interfere throughout the data collection process and to impose my understandings on the data. In other words, I should allow the data to emerge in their own form and speak for themselves (Crotty, 1996). I will make every effort to be nonjudgmental and open and accept my participants' life experiences as their truth.

#### *Bracketing by the Researcher*

During the course of designing this study, I applied bracketing by writing my preconceived notions about the sampling, expected themes, and participants prior to conducting the study. During the interviews in data collection, I wrote my preconceived notions in a notebook while at the SHAPP clinic between interviews and immediately after each interview. I wanted to be aware of these ideas so that in my data analysis I only report from the participants' experiences as they are stated in the transcript.

#### *Description of Sample Population and Surrounding Area*

The participants were sampled from the Northeast Georgia Health District's Clarke County Health Department located in Athens, Georgia, which is located in the northeastern section of the state. This community has a majority White population and consists of working class African American adults that reside in the center of Athens. The Athens area has extreme income disparities, and thus extreme ranges of access to healthcare services. In Athens, 30.8% of the population lives below the poverty level and 25.3% of the population are African

Americans (Bureau, 2010). In Georgia, high rates of cardiovascular disease (CVD) are prevalent, as stated earlier in Chapter 1. Based upon data reported to the U. S. Census Bureau (2010), the following statistics on Clarke County are listed in Table 15 below:

Table 15

*Demographics of Clarke County, Georgia*

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<u>Description</u>	<u>Clarke County</u>
Total population	116, 342
% 65 years and older	8.6%
% of Whites	69.7%
% of African Americans	25.3%
Median household income	\$36,254
Unemployment rate	7.9%
% Below the Poverty Level	30.8%

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Source: U.S. Census Bureau (2010)

The following education, health, and public assistance statistics from the University of Georgia (UGA) are reported for Clarke County in Table 21 (UGA, 2010).

Table 16

*Education, Health, and Public Assistance Statistics in Clarke County, Georgia*

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<u>Description</u>	<u>Clarke County</u>
Education -Public School System	

% of African American students	55.1%
% of White students	19.8%
% economically disadvantaged	70.8%
Class of 2008 completion rate	63.1%
% of grads with college prep diploma	70.1%
Education – Highest level completed	
% Not completed high school	19.0%
% High school graduates (includes GED)	21.6%
% Some College and/or Associates degree	19.6%
% Bachelor’s degree	20.9%
% Graduate or professional degree	18.9%
Health	
Disability, % age 21-64	16.3%
Disability, % age 65+	44.0%
General hospitals	2
General nursing homes	4
Persons per physician ratio	308.0
Public Assistance	
Food stamp recipients, % of population	10.0%
Medicaid recipients, % of population	18.1%
<u>Social Security recipients, % of population</u>	<u>11.6%</u>

Source: University of Georgia (2010)

*Site of Data Collection*

The Northeast Georgia Health District’s Cardiovascular Health Clinic served as the site of data collection. This clinic participates in the state’s Department of Community Health Stroke

Heart Attack and Prevention Program within the Division of Public Health (DPH) and ongoing since 1972 (DPH, 2010). The Georgia Department of Human Resources states (DHR):

DHR's Stroke and Heart Attack Prevention Program (SHAPP) is an awareness, detection, treatment and control program that targets low-income, uninsured or underinsured patients with uncontrolled high blood pressure. Funded in part by the Georgia General Assembly, the SHAPP program aims to reduce illness and death from cardiovascular disease associated with high blood pressure. There are 137 SHAPP clinics around the state, and they are partnerships between public and private health care providers. Drugs aimed at reducing high blood pressure and guidance around lifestyle changes are made available in clinics to eligible patients. Once a patient's blood pressure is under control they are generally seen on a quarterly basis (Resources, 2007).

This clinic serves adult patients either with a primary care private physician and those without one in the Northeast Georgia Health District, mostly from Athens. The patients are primarily adult African American men and women. Patients who are joint managed visit a private physician for an initial hypertension diagnosis and prescription, then come to the health department's SHAPP clinic for continual BP checks, nutrition and medication counseling, weight management, physical activity, and smoking cessation counseling by nurse practitioners. For uninsured patients, the SHAPP clinic offer an initial history and lab tests. After an initial diagnosis of hypertension is made, nurses order therapy and the patients schedule visits to the health department for BP control.

The following data is reported from the SHAPP Northeast Health District (NEGA) management (Appendix Tables A1-5) (NEGA, 2009). According to data from the 2009 Fiscal Year's second quarter, SHAPP control rate in Northeast Georgia Health District was 66.4%

compared with the state average of 67.4%. In the 2009 Fiscal Year, the majority of active male SHAPP clients managed at the health department aged 35-64 were White (Appendix Table A1). Among those men with controlled BP, 54% were African American, 54% were White, and 67% were of another race (Appendix Table A1). The majority of active female SHAPP clients aged 35-64 were African American (Appendix Table A2). The majority of women with controlled BP were African American (Appendix Table A2). Among all SHAPP clients, 25% were smokers, 19% were diabetics, 90% received weight management counseling, 88% received physical activity counseling, 22% received tobacco cessation counseling, 80% received medication counseling, and 87% received nutrition counseling (SHAPP, 2009).

### *Sampling*

For this study, I used purposive sampling to select participants and semi-structured interviewing to collect data (Creswell, 2007; Kvale & Brinkmann, 2009; Rossman & Rallis, 2003). Purposive sampling means that the researcher selects individuals and sites for a study because they can purposefully inform an understanding of the research problem and central phenomenon (Creswell, 2007). Inclusion criteria were White and African American adults aged 55 and above, attending the Athens cardiovascular health clinic, and either controlled hypertension (<140/90 mm Hg) or uncontrolled hypertension (>140/90 mm Hg) from the last 2 visits in the medical records. The minimum age of 55 and above was chosen because of the sharp increase in HTN prevalence according to Tables 5 and 6 in Chapter 1 (p. 6-7). Exclusion criteria were adults who did not speak fluent English, multiple chronic diseases other than diabetes, and had the cognitive ability to complete the interview. No participants met these exclusion criteria in the study.

### *Number of Participants*

According to deMarrais (2004), the number of participants necessary for a qualitative study depends on the richness of the interviews and the extent to which the participant is willing to respond to the interview questions. “A good interview of approximately one and a half hours may yield a transcript of 25 to 30 pages of text” (deMarrais, 2004, p. 61). As the researcher, I will need to interview enough participants to gain an understanding of the phenomena of living with hypertension. Fewer participants interviewed in greater depth generates an understanding sought in qualitative research. When similar patterns appear from the answers of participants or when little new information is received from the interview data, this is the time to stop the interview portion of the study (deMarrais, 2004). Thus, I selected 29 participants from the Northeast Georgia Health District’s Cardiovascular clinic and selected participants until theoretical saturation has occurred. Theoretical saturation is the “point at which gathering more data about a theoretical category reveals no new properties nor yields any further theoretical insights about the emerging theory” (Charmaz, 2006, p. 186). This small number for the sample is suitable because qualitative methods are used for problems to be studied in-depth and produce a great amount of detailed data about a small number of people and cases (Patton, 2002, p. 227).

### *Training of Nurse and Clinic Staff*

Training of the nurse and clinic staff occurred prior to advertisement, recruitment, and interviewing of participants. During my scheduled meeting with the nurse and county health department manager, we discussed the screening inclusion criteria and exclusion criteria on which we would recruit participants for my study. In a meeting of 30 minutes in duration, I explained the purpose and overview of my study and asked for their approval to conduct interviews at the county health department’s Cardiovascular Health clinic. The nurse and county

health department manager were White and close in age to the participants. The two staff members at the clinic were African American females in their 30s and 40s.

### *Recruitment of Participants*

To identify potential participants and for confidentiality purposes, clinic nurse and two staff members screened those aged 55 and above, males and females, and White and African American patients with either controlled or uncontrolled hypertension according to medical records to determine if they met the eligibility criteria for the study. The clinic staff announced my study to prospective participants in the Athens cardiovascular health clinic as they signed in to register at the front desk of the clinic. I remained at the clinic during their operating hours of 8am to 5pm Monday through Friday for a period of five weeks. The clinic nurse, health department manager, and I agreed that recruitment may increase if patients were introduced to me in person in the clinic versus reading a flyer posted on the wall. After completion of their visit with the nurse, the nurse then introduced my study to prospective patients and then introduced the patients to me in a separate room in the clinic (Appendix B). Then, the patient decided if he or she would or would not participate in the study. Flyers advertising the study were posted in the clinic's waiting room, near the registration desk and distributed to patients upon completion of the visit (Appendix C). All patients who were invited to participate by the nurse agreed upon meeting me in person.

### *Data Collection Procedures*

I selected participants currently enrolled in the state's Stroke Heart Attack and Prevention Program (SHAPP). After their clinic visit with a nurse, I invited potential participants into a separate office in the clinic. They answered brief questions to report demographic information (age, race, education level, length of enrollment in SHAPP) and to determine if they



demonstrated the cognitive ability to complete the interview (Appendix D). I utilized face-to-face semi-structured interviews to collect data (Belenky, Clinchy, Goldberger, & Tarule, 1997; Kvale & Brinkmann, 2009). In my interview guide I prepared an outline of questions to be covered; however, I decided how specifically I adhered to the guide and how often I asked a probing question after a participant's answer (Appendix E) (Belenky, et al., 1997; Kvale & Brinkmann, 2009). Initially, I conducted preliminary interviews with four participants. These first four interviews were a test of my interview protocol in terms of timing the interviews, determining the proper wording of questions, and determining preliminary themes before conducting interviews with the selected sample. Following analysis of the preliminary interviews, I conducted interviews with an additional 25 participants.

I accounted for ethical concerns before each interview. Before starting the interview, I attained informed consent from the participant (Appendix F). Before conducting the interview, I informed each participant of the purpose of my study, that I will audiotape the interview using a digital recorder, and will assign each participant a pseudonym for the reporting of my results. I ensured their confidentiality by placing the interview tapes in a locked, secure room in which only I have access. Once I transcribed the interviews, I destroyed all interview tapes.

In gathering their data, phenomenologically oriented researchers are trying to ensure that the subjective character of the data is left intact and untainted. First, they pay attention to the manner in which they conduct their interviews: examples include unstructured, semi-structured, or open-ended interviews. Whereas a structured interview follows a set number of predetermined questions, unstructured, semi-structured, and open-ended interviews allows the interview to develop spontaneously. The goal of a phenomenological interview is to attain a first-person description of a specific lived experience, which is hypertension in this case. The course of the

dialogue is largely set by the participant. Crotty describes this:

The dialogue tends to be circular rather than linear; the descriptive questions employed flow from the course of the dialogue and not from a predetermined path. The interview is intended to yield a conversation, not a question and answer session (Crotty, 1996, p. 21).

Other follow-up or additional probing questions followed after those questions listed in the interview guide depending on the answers of each participant. A way that I may ask the participants to share their thoughts, perceptions, and feelings about a situation is to ask them these phenomenological questions, What was it like? or What does it mean for you? (Crotty, 1996).

Furthermore, the interview context I utilized is described as the following:

The interviewer [should] provide a context in which participants freely describe their experiences in detail. The interviewer does not begin an interview feeling that he or she knows more about the topic than the participant. An important aspect is that the interviewer and the participant are in positions of equality. The interviewer does not want to be seen as more powerful or knowledgeable because the participant must be the expert of his or her own experiences (Thompson, Locander, & Pollio, 1989, p. 138).

The questions and probes I utilized aimed at describing experiences of the participants. The dialogue should be focused on a participant's specific experience rather than abstractions about hypertension. Focusing on specific events enables the participant to provide a fuller, more detailed description of his or her lived experience. Asking "why" questions should be avoided since these questions shift the focus on the dialogue away from describing the lived experience to a more abstract discussion (Thompson, et al., 1989). Furthermore, Thompson et al. discusses steps on how to attain a phenomenological dialogue which I will utilize in my interviews:

Operationally, the interviewer desires to be a non-directive listener. The interviewer guidelines of establishing equality among participants [include] having questions follow from [participant] discourse, employing short descriptive questions, are some methodological procedures for preventing the interviewer from assuming an overly intrusive role. The ideal interview format occurs when the interviewer's short descriptive questions and/or clarifying statements provide an opening for a [participant's] lengthier, detailed descriptions. (p. 139)

I attempted to develop a form of data collection that invites and facilitates authentic accounts of subjective experiences. After all participants are interviewed, I transcribed the interviews, then listen to the tapes again for accuracy. Next, my task was to analyze these accounts without distortion and with respect for the participants' lived experiences.

#### *Incentives*

Participants were provided with a \$20.00 Walmart gift card before the interview for their participation in the study. Participants completed a payment form for auditing purposes for the department funding the Walmart gift cards (Appendix G).

#### *Informed Consent and Human Subjects*

At the request of the participants, I read the instructions in the consent form to each of them to ensure that they were informed of the purpose of the study prior to agreeing to participate. They were asked to read and sign the consent form prior to the interview. To protect the rights of human subjects, the project was reviewed by the University of Georgia Institutional Review Board prior to any data collection.

### *Data Analysis Procedures*

Interviewing and data analysis occurred concurrently in the study. After the interviews were conducted, they were immediately transcribed, and then my interpretations in data analysis began. My sole reliance on verbatim transcripts will reflect three methodological criteria of phenomenological interpretation – the emic approach, autonomy of the text, and bracketing (Thompson, et al., 1989). The interpretation relies on the participant’s own terms and category systems rather than those of the researcher. Second, the text of the interview is an autonomous body of data consisting of participant reflections on lived experiences, which has two aspects. First, I made no attempt to validate a participants’ description from external sources since the participants’ experiences are their truth. Second, my interpretation should not integrate hypotheses, inferences, or assumptions that exceed any evidence provided by the transcript. Third, to treat the transcript as autonomous data, I bracketed my preconceived notions about the phenomenon of hypertension.

For data analysis, I utilized the Colaizzi-style method (Colaizzi, 1978). Crotty notes this method consists of “reading the descriptions, extracting the significant statements, formulating meanings, organizing formulated meanings into clusters of themes, exhaustively describing the investigated phenomena [of hypertension], and validating the exhaustive description by each participant” (p. 22). Colaizzi describes the steps of the process (p. 59-61):

1. All participants’ oral or written descriptions are read in order to obtain a feel for the whole.
2. Significant statements and phrases pertaining directly to the phenomenon are extracted.
3. Meanings are formulated from these significant statements and phrases.
4. Meanings are clustered into themes.
5. Results are integrated into an exhaustive description of the phenomenon. (p. 259)

In Colaizzi's Step #1, I listened to the participants' audiotapes and read their transcripts in order to obtain an understanding of their experiences living with hypertension. In Step #2, I extracted relevant statements and phrases pertaining directly to living with hypertension to gather in-depth details on their lived experiences. In Step #3, I formulated meanings from these significant statements and phrases in order to answer my research questions I posed and make an interpretation about the participants' lived experiences as applied to hypertension control and management.

Essentially, I derived themes or categories from the data, then combined them to form a comprehensive description of the phenomena of hypertension among elderly Whites and African Americans. Data analysis continued until I determined that a point of saturation has been reached with the emergence of regularities or patterns in my data. To keep with the emphasis on obtaining and maintaining truly subjective data, I did not impose certain themes as categories during analysis (Crotty, 1996). I allowed themes to arise from the data themselves, by reflecting on the data and uncovering common themes from particular quotations. Also, I recorded ideas that have occurred to me but cannot attach to particular sections of data.

For this study, I utilized the conceptual framework of phenomenology to answer my research questions (p. 3) as stated in the upcoming results in Chapter 4. In Chapter 5, I offer an assessment of results in Chapter 4, the strengths and weaknesses of this qualitative design, lessons learned from conducting this study, unexpected experiences and findings. Finally, I propose future directions and recommendations for practice, research, education, and policy.

## CHAPTER 4

### RESULTS

This chapter describes the findings of this study and is organized in the following manner: 1) the demographics of the participants, 2) shared lived experiences of the patients in the Georgia Stroke Heart Attack and Prevention Program (SHAPP), 3) race differences in terms of the participants' experiences, 4) and gender differences in terms of the participants' experiences living with high blood pressure. Each sub-section is followed by a brief summary and a final summary at the end of this chapter. The research questions posed for this study are the following:

- 1) What are the lived experiences of White and African American men and women diagnosed with hypertension?
- 2) What are the differences in the experiences between Whites and African Americans?
- 3) What are the differences in the experiences between men and women?

#### *Demographics*

The sample consisted of 29 active patients (9 men and 20 women) participating in a state Stroke Heart Attack and Prevention Program at a County Health Department in a state Health District. The clinic's patients were predominately African American, with a few White patients. The patients interviewed were 28 African American patients (20 female and 8 male) and 1 White male patient, between the ages of 55 and 75. The mean age was 62 years old ( $M = 61.90$ ,  $SD = 5.62$ ). Thirteen were unemployed, twelve were currently working, and four were retired. Twenty-one patients were uninsured with no other physician or healthcare provider and the SHAPP clinic as their only source of healthcare. Only 8 of 29 patients had insurance coverage. Seven of 29 participants were diabetic. The majority of participants had a high school education

level ( $M = 11.20$ ,  $SD = 1.84$ ) as 3 had less than high school, 7 had some high school, 14 graduated from high school, and 5 completed some college. The majority of participants were parents and grandparents. In terms of marital status of the participants, 4 were widowed, 5 were divorced, 12 were married, and 8 were single. The majority of participants had received hypertension treatment for 18 years ( $M = 7.86$ ,  $SD = 12.07$ ) and had been coming to the SHAPP clinic for 10 years ( $M = 10.45$ ,  $SD = 9.79$ ). Table 17 displays the demographic information for each participant, identified by the pseudonym assigned before the interview.

Table 17

*Participant Demographics*

<b>Name</b>	<b>Age</b>	<b>Race</b>	<b>Education (years)</b>	<b>Current job</b>	<b>Years of HTN treatment</b>	<b>Years coming to BP clinic</b>	<b>Status of HTN control</b>
Andy	57	AA	12	Secretary	5	20+	Controlled
Lucy	59	AA	12	Unemployed	20	20+	Controlled
Carrie	75	AA	9	Unemployed	15	1	Uncontrolled
Paula	70	AA	12	Unemployed	30	20	Uncontrolled
Rachel	55	AA	12	Unemployed	1	1	Controlled
Nancy	57	AA	12	Nursing aide	8	2	Controlled
Billy	55	White	14	Construction	10	3	Controlled
Tom	62	AA	12	Retired	25	2	Controlled
Lisa	67	AA	11	Unemployed	35	35+	Uncontrolled
Erin	61	AA	10	Cafeteria worker	31	31	Controlled
Larry	63	AA	13	Unemployed	3	1	Controlled
Katie	63	AA	13	Unemployed	5	5	Controlled
Joe	70	AA	12	Caregiver	30	7	Controlled
Whitney	69	AA	10	Unemployed	24	20	Controlled
Hannah	58	AA	11	Unemployed	10	10	Controlled
Gary	58	AA	12	Retired	10	5	Controlled
Jackie	56	AA	12	Hotel maid	45	10	Controlled
Harry	65	AA	12	Store worker	20	10	Controlled
Nancy	70	AA	10	Retired	35	10	Controlled
Nicole	62	AA	14	Cleaning maid	6	1	Controlled
Sherrie	70	AA	8	Factory worker	5	5	Controlled
Kelly	57	AA	9	Store worker	15	15	Controlled
Julia	55	AA	12	House cleaner	24	5	Controlled

Harriet	60	AA	12	Supervisor	3	3	Controlled
Stanley	61	AA	7	Unemployed	35	1	Controlled
Gabby	59	AA	12	Unemployed	10	10	Controlled
Wanda	60	AA	13	Unemployed	10	2	Controlled
Tamyra	55	AA	10	Unemployed	23	23	Controlled
Ralph	65	AA	7	Retired	25	25	Uncontrolled

\*AA = African Americans

#### Findings from the interviews

The following data presents the common patient experiences that resulted from analyzing the 29 interview transcripts.

*Research Question #1: What are the lived experiences of Whites and African American men and women diagnosed with hypertension?*

I found themes relating to Research Question #1 that included clinical experiences, barriers to healthcare, experiences with other healthcare providers, and experiences with the first diagnosis of hypertension. Below are examples describing how each of these themes emerged followed by a brief summary of each theme.

#### *Clinic Experiences*

The first set of questions I posed to participants to answer this first research question were: 1) Tell me about the medical care that you received at this clinic. 2) Tell me about the care you are getting at this clinic (Appendix D). All patients described their high satisfaction with the clinic in terms of the high quality, compassionate care from the nursing staff, low cost of the blood pressure medicines, and being accepted as a low income, uninsured patient in the SHAPP clinic. Although I did not ask the question, patients praised the clinic by comparing their experiences at the SHAPP clinic to previous experiences with other private healthcare providers in the past and their change from noncompliance to compliance while in the SHAPP clinic.

Hannah, an uninsured patient discussed her experiences at the clinic:



I know a lot of people say a job is a job. But I find out working with people if you come in and you got all these medical problems and the nurse or whatever act like they don't care. But [the nurse] asks when I come in, you know how you feeling or whatever, or what's going on? It's not like [the nurse is] just treating me for the high blood pressure and the diabetes or whatever you know because she gotta do it. She's concerned and I like that. Because a lot of people they don't really care. They'll say it's a job. But I don't find that to be true here you know. And I can say that.

Hannah remarked on how the nurses showed great concern to her during her patient visits. The nurse is concerned for the patient's overall well-being beyond the treatment for the high blood pressure. The nurse treats Hannah with respect and as an individual rather than merely a patient needing a prescription refill for a six month supply of blood pressure medicines.

Larry, another uninsured and unemployed patient discussed the staff at the SHAPP clinic: Oh my God I mean just a couple of words. The staff are just fantastic, just great. There's a warmth that comes from both of them even though they're like in two different offices the nurse shows nothing but true concern for my health and, and I mean it's almost like a mother figure. And I mean I'm older than she is but she wants to take better care of me than I'm willing to take care of myself. You know and just so warm and passionate of a person [coughs] and the other young lady she's, she's so sweet as honey I mean. I've never felt you know any kind of threatening tones any kind of anti-socialness from any of them it's always been a warm feeling and it just, it's real professional and I, for the price of what they're doing the medicines for I mean I couldn't beat it. It's just a blessing. I'm just impressed. I'm grateful. My doctor recommended this clinic to me because of my financial situation so I'm just thankful that there is a place like [this] for a person who's indigent or on a fixed income.

Larry remarks on how the nurse demonstrates true concern for his health and treats him as an

individual rather than a mere patient diagnosed with hypertension. His gratitude for the opportunity to attend a clinic such as this one stems from his urgent need to control his high blood pressure and need to gain access to healthcare.

Nancy expressed her positive feelings about the clinic:

Wonderful care. I wouldn't, I wouldn't wanna be nowhere else. I don't believe I could be as comfortable. I am comfortable here. We can sit down and have a conversation. We can laugh and talk and ask questions. You know I just feel comfortable with them and they been here long time and I had been coming here a long time. And when you feel comfortable around a person, that's where you'd rather be. I do. Everytime I come they are very friendly. Everytime. Never had a visit make me feel bad about seeing the nurses. They are very friendly. I see it in front of their face and I'll see it behind they back they are. Because I'm a person if I feel uncomfortable I ain't got to come here you know cause I got my Medicaid. I got my card, my medication card, my Medicare card, my insurance card. I can go anywhere I wanna go you know what I'm saying?

Nancy's feelings of comfort stem from her rapport with the nurse and staff during her clinic visits. Her decision to continue coming back to the clinic is one based on her personal feelings toward the nurse and clinic staff. Although she has insurance, she still chooses to go the clinic to control her blood pressure instead of a private physician, demonstrating the great extent of her loyalty to and sincere appreciation of the clinic staff.

Harry narrated his experiences with the nurses:

What they tell you is backed up with the pamphlets that they have. And they don't mind sharing the pamphlets that they have. And if you have a question about your blood pressure [they answer it]. Every time you come here for an examination the first thing they wanna know do you have dizzy spells? Do you have blurred vision? And blood pressure causes this and if you have a problem and don't understand it, they have

pamphlets they can give you. And she started me off with blood pressure medicine twice a day, in the morning and at night and in the afternoon. She did that for about 2 months, brought me back for a physical to try to find out the type medication to give me and once once they got it normal well they could work with it. That's where it leveled off at and that's when she told me to continue on with the medication she gave me along with the pills and exercise watch the type of food that I eat and salt also brought in a dietician to tell, explain to me the types of food and how to cook it and everything which it helped and if a person is hardheaded and don't wanna listen, they do not need to be in this blood pressure program that they have at this clinic. Because the peoples here to me have been good to me all throughout the time I had been here. And I'll tell anybody if they suffering with high blood pressure and don't have the money to see a family doctor come here. They will work with you until you get to the point you been getting don't wanna listen. They cut you loose. And that's just like I said, my experiences here with them in this clinic have changed my life and in other words to get me to see what high blood pressure mean. High blood pressure can strike anybody regardless of race, creed, or color. And I tell [people] all the time, if you don't have any money come here, they'll help you. Get checked to find out how it is.

Harry describes the nurse's willingness to educate the patients by giving them pamphlets during their clinical visits to read and take home with them. The distribution of these pamphlets demonstrates the nurse's caring nature in interacting with patients in the clinic and wanting the patients learn the necessary lifestyle changes to control their blood pressure.

#### *Summary of Clinic Experiences*

All 29 patients reported high satisfaction with the medical care they received from the SHAPP clinic staff. The overall trends from the results demonstrate the compassionate nature of the clinic nurse and how the patients are treated kindly as individuals by the clinic staff. The

nurse is willing to educate patients on the risk factors of hypertension and lifestyle changes to lower their blood pressure in a gentle and caring manner in which patients feel valued and respected as individuals.

### *Barriers to healthcare*

This theme was determined from analyzing the answers to the questions addressed in the previous section for Research Question #1. The following barriers are discussed: lack of money, lack of access to healthcare, missing appointments at the clinic, lack of motivation to exercise, and fear of falling from exercising. Each barrier is presented with a supporting example from a participant. In addition to describing each barrier, I also present an example of exceptions to each of these patterns to indicate the variations for each barrier.

#### *Lack of money*

Most, but not all of these low-income respondents discussed the challenges of poor finances. Tom, an uninsured patient who is also a Type 2 diabetic, discussed his struggles with money and the low cost of the medicines at the clinic:

Money. Don't have the funds well get it here it's different because you don't have to pay as much as \$30 for 6 months supply that's not bad. But the insulin they don't have that here. That's what eat you alive is the insulin and the uh the strips. Diabetic strips.

That's why I have problems with that. The strips. I have my own meter though. I have to scuffs sometimes to get that insulin. I don't run out or anything but I wind up borrowing from everybody, borrowed money to keep myself they don't give away nothing.

Tom demonstrates his personal struggles to pay for his insulin and testing strips to manage his diabetes. His access to insulin and diabetes testing strips is based upon the availability of money in his life at any particular time. Tom's experiences show the impact of money on paying for his medicines thereby influencing his ability to control his high blood pressure and diabetes.

Katie, an uninsured and unemployed patient shares information on her financial situation. And [the clinic is] less expensive [than a private physician] and I was about to go to the [private] doctor and it's like 74 dollars a visit. And I probably couldn't get the care I needed cause I probably couldn't afford to go. As many times as I have to come back here.

Katie discussed her financial burden which impeded her from seeing a private physician in the past to control her blood pressure. She is grateful to the SHAPP clinic staff for accepting her as a patient despite her poor financial situation.

Kelly described her reasons for purchasing the medications at the SHAPP clinic:

One thing is that I can't afford to buy my medications from the drug store when I get it cheaper this way [at the clinic]. At least I have to pay still but it's not like going to the regular [private] doctor and then the drugstore help me out.

Kelly explained that she cannot afford to buy her blood pressure medicines from the drugstore and also pay for a private doctor's visit to obtain the prescription. She is thankful for the low cost of the blood pressure medicines provided to her at the SHAPP clinic.

Wanda described her struggles to pay for her blood pressure medicines:

When I had high blood pressure I was in the hospital. I had 2 cysts so they did like a hysterectomy but my doctor she had you know she was running doing everything she could do with blood pressure tests and stuff like that. That's when I started getting on the pills and they got me because the pills that was giving me they, they figured it out a better type of pill you know I could take and be less expensive. The one I was taking from the [private] medical doctor was way expensive. It was 40 dollars for 30 for a one month supply and I'm not getting that much from my pension. I'm not getting more than 200 dollars from my pension so I couldn't afford that see. Couldn't afford that.

Wanda recalled her previous struggles to pay for her medicines from her pension. Her struggles

demonstrate the impact of a poor financial situation on limiting her ability to pay and take her blood pressure medicines as prescribed. Similar to the previous patients, Wanda appreciates the low cost of blood pressure medicines offered at the SHAPP clinic to assist those patients in financial need.

However, not all participants experienced a lack of money to pay for their medicines. Nineteen of 29 participants did not report any experiences with financial difficulties. Perhaps these participants may have experienced financial difficulties, but perceived them as a challenge to overcome not as an overwhelming burden to bear. Nicole commented:

The cost of the medication is not a problem. No it's really helped since I been coming here [to the SHAPP clinic]. I used to get them for \$4 at the store when I had insurance but this they give me a 6 month supply for \$30 you know with the checkups too so that's really great for me.

Nicole reported that she is satisfied with the low cost of her blood pressure medications at the SHAPP clinic. Although she was able to get her medications previously with insurance, she is satisfied with the inclusion of the clinic visit in the \$30 fee.

#### *Missing appointments*

Some, but not all participants recalled their challenges of following their appointments at the clinic. Natalie described her reasoning for missing a recent appointment at the clinic:

I didn't [come] the last time and my reason for not following it the last time is because I, I was like thinking okay I don't have the funds since my other job ended I didn't have funds. I was kinda skeptical about coming. I supposed to actually have been here in January I didn't come until April and I told her you know I said well the reason I didn't come I said I just never have the funds. My car was tore up and I was working less hours. She said that shouldn't have stopped you. You should have just called and if you didn't have any [money] at the time you know you should have come anyway. You

know and I was like telling her well you they're all these signs up saying you know money on upon you getting treatment. And I'm like okay and that's why I didn't. But she told me no. Cause she asked me if she say well do you have a balance here? And I'm like "no I don't have a balance." Then she say you're good then "don't ever do that, don't ever do, don't ever do that you know." And my blood pressure now I kept an eye on it then cause I run out of medication the end of January so for February, March I didn't have any medication and the highest my blood pressure got was like 156, 157/80 something about 89, 80 something. And that was as high as it got what had happened. It never really just got high whatever but I was strictly watched what I really ate and sometimes not eating too cause I was like okay. If I had been reminded, I would have make an appointment to come cause I don't need to keep doing this. I'm risking my health and my life by doing this. So I made up my mind and call them here and I had told her you know uh that I needed to come and she said like "well why are you waiting? You don't have a bill here!" I said to her "I'm so sorry, I had been saying once you get treatment you know you need to have your money to pay em whatever. So you know me I, I know I didn't have the money so I was already on a budget thang as it was you know try to make end meets and I had to eat at home you know so I was like okay I just don't have the funds. I just don't have the funds. But you know now I've learned you know she told you know our billing is like, don't worry about that you just come on anyway. They both told me that. And and I really thanked them for that and I really admired them for that. Cause she said we're talking about your health here. You know hey we know you gonna pay you had, you had ever since you been coming, you'd never not paid you know. So it wouldn't, it wouldn't be a problem. And so they explained that to me but I just felt bad cause I didn't have it you know.

Natalie discussed her internal struggles trying to decide whether she should go to the clinic

even though she had no money and unable to pay for the \$30 visit and blood pressure medicines. She had previously reported low self-efficacy and was not motivated to come to the clinic to help control her blood pressure until she realized she was endangering her physical health. This insight increased her perceived susceptibility and she was then motivated to go to the clinic. She felt shame and embarrassment in disclosing her financial troubles to the clinic staff and thus was avoiding going to the clinic for a period of time. Finally she decided that her health is her priority, and thus she decided to put aside her shame and embarrassment and seek treatment to control her high blood pressure at the clinic.

However, 20 of 29 participants reported that they have never missed an appointment at the clinic. Lucy related:

I take my blood pressure pills on time everyday. And doing what the nurse tell me. Yes. Yes. I follow every appointment as I should. I never miss an appointment. One is because I'm losing weight. One is because my blood pressure is normal and my diabetes is normal – never too high, never too low, but just right. And my blood pressure always be normal and so they let me know that I'm doing the right thing and I take my medicine maintain right you know blood pressure and everything but it – it's just marvelous. It's great.

She emphasized her self-discipline in continuing to go the clinic to control her blood pressure, receive nurse counseling on her diet and exercise plans, and refill her blood pressure medications. Lucy strictly adhered to the nurse's instructions to control her blood pressure and place her health as a major priority in her life. These behavior changes indicate the tremendous success of the clinic staff in supporting their patients to control their blood pressure.

Kelly discussed her situation when she missed a recent appointment at the SHAPP clinic:

Yeah I missed an appointment but that's what I'm talking about. She didn't fuss at me because I missed it. She just wanted to know why, but it was during the time when



something was going on with the front girl and then my daughter had been in an accident in Atlanta which is when I had called but then after I did, it didn't occur to me that I needed to call back when I didn't get nobody. It just kept slipping my mind until I picked up my medicine bottle and said Ooooh Lord I'm out of medicine. And I went back.

Kelly described her recent situation in which she missed an appointment because of her daughter's accident and not clearly communicating with the SHAPP staff. When she noticed her empty medicine container she was shocked and quickly returned to the clinic for a refill. This situation increased her perceived susceptibility and she quickly exercised her self-efficacy to obtain another refill of her medicines to control her blood pressure. She did not place her appointment and health as a top priority; however, when she ran out of blood pressure medicine she was motivated to return to the clinic to obtain a refill.

#### *Access to healthcare*

Hannah discussed her prior difficulties in obtaining access to healthcare and her satisfaction in finding this SHAPP clinic:

I mean it's great for me because when my job closed down you worked all these years and you've had health insurance. And my concern was how am I going to be able to get this medicine I know I need you know. But if you don't have insurance you can't go to doctors. And someone brought it back to my remembrance you know they say I'm not sure exactly you know if you ain't got insurance, if you don't have no income, there's something you can do there you know that you can get your medicines so it was a blessing for me to be able to come here and get my medicine. Because otherwise I don't know what I would have done. Because you know if you can't, if you can't go to the [private] doctor, you can't get a prescription, if you don't have the money you can't pay anyways so I mean it's really been a blessing for me.

Hannah's unemployed status and lack of insurance had previously affected her mindset to not

seek treatment to control her high blood pressure. Her inability to pay for the blood pressure medicines is the reason she did not seek healthcare in the past. She talked about the subjective norm that health insurance is necessary to visit a doctor to obtain prescriptions and control blood pressure. Since she did not have health insurance, she chose not to control her blood pressure. During her interview, she demonstrated gratefulness for the opportunity to meet the clinic staff, who openly accepted her into the clinic as a patient despite her lack of health insurance.

However, some participants had access to healthcare. Although Gabby was unemployed, she had health insurance coverage and was seen by a private physician.

Gabby said:

[The clinic] give real good care. When I first started coming here, my blood pressure run up about 300 something over 200 something and you know was a lot of problem with my blood pressure and then when I started coming here you know they helped get it regulated they have to start me on a lot of different medicine and then I started going to the doctor and he had to start you know. They both worked together and got my blood pressure under control.

Gabby reported on the working relationship between her private physician and the SHAPP nurse on collaborating to control her blood pressure. Gabby remarked on her high satisfaction on lowering her extremely high blood pressure to normal levels and her motivation to continue visiting the both the clinic and her private physician.

#### *Lack of Motivation to Exercise*

Some, but not all, participants discussed their lack of motivation to exercise and comply with the nurse's instructions. Paula stated her feelings of loneliness and lack of motivation to leave her house to exercise:

Something else that scares me and I'm, I'm thinking sitting here talking with you is that my lifestyle that I've got going now with the couch potato business. I need to get out and

exercise because my body is talking to me. I'm stiff I won't have the strength in my hands and it wasn't like I used to. Not even halfway really. Like to open the jar you know. I don't have that, that grip anymore. That's number one. Lazy. And then like I said when you're feeling "Yeah what the heck" that's why I said it's a depressed mood that I'm in. Well you know what's the sense in putting on your clothes. "When you're going?" You know, I don't drive anywhere I go somebody has to take me. So I just stay in my little, my little cubbyhole my house. Not my house, it is my apartment. Anyways so I've stayed in and I was getting out walking to the mailbox and then my son started going picking the mail up and so I stopped. So I don't even get up to do that. You know all the walking, all the walking I get is around the apartment from room to room. And then I sit on the couch but my legs, my legs at night sometimes start to tingle and then makes me think my circulation's getting low. I gotta get up and start doing something. The only time I get out is I try to get to church on Sundays.

Paula discussed her perceived barrier, lack of motivation to exercise, however she recognized her need to start exercising immediately. Paula's grief over her deceased husband continued to plague her mind as she recognized her depressed mood and need to change her sedentary behavior. Paula needed social support from a family member or friend to assist in motivating her to exercise and also exercising with her when she leaves her apartment. Her motivation to comply with the nurse's instructions to exercise was low and she displayed low self-efficacy to control her blood pressure.

*Fear of falling from exercising*

Some, but not all participants mentioned their fears of falling from exercising outside of their house. Lisa discusses her physical ailments which prevent her from exercising:

I used to exercise but now I hadn't gotten back into exercising. Not yet. I used to walk Everyday go for about 2 miles walking everyday. Well I started problems with my knee.

I think my cartilage in my knee, they get, I get weak in my knees and sometimes I can't go for a long walk. I'm scared that I might fall. I can get up and be more active. I think I need someone to exercise with me. It would help a lot. Then I would have someone in the morning to tell me "Let's get up and walk. Go to a gym. Do some aerobics." I can't do aerobics though.

Lisa's fear of falling from exercising was a perceived barrier to her hypertension control and management as decided to not exercise due to her physical limitations. Although she realized her need for social support and the importance of exercise, her fear inhibited her from making the effort to exercise. Lisa reported low self-efficacy to exercise and control her hypertension.

However unlike Paula and Lisa, some participants were strongly motivated to exercise and had no fear of accidents from exercising. They indicated their high self-efficacy and confidence in their accounts to improve the frequency and duration of exercise to control their high blood pressure. Joe said of his experiences with exercising,

I walks every morning for about an hour and a half and so. About an hour and 15 minutes. Hour and 15 minutes. Everyday. Yeah. Right. Alone cause I don't like walking. I like, that as my time alone. I don't like walking with a group or nobody. I just walk alone. Yeah. I enjoy it. Yeah, I feel like it's, it's, it's it's a healthy thing to do and after I get into it. At least I was doing it before I retired and years ago when doing it's regular. I do it regular now and I feel like it's you feel better from doing it you know for health reasons you know once I got into you. When I don't do it, I can tell the difference. You know so that keeps you work, work, working your blood pressure down. And it Seems like once I got started doing it. It's hard to not do it everyday. [When I don't walk] I feel like maybe, feel you know like junk, not real good and about when I don't walk I will definitely have like I guess like acid reflux cause what not it make you feel more

better in the chest when you do walk. I don't walk some, some days or two you can tell it that you're clearly coming on so. [In the morning] that's what I gets up for because I gets up the same time I was when I was going to work like you can't get away from that. And I get up and so that's what I say I got to do. Like I say I gotta go to work like I gotta go for my walk. So the thing I do in the morningtime.

Joe reported that he made health and his blood pressure control a major priority in his life and was able to organize his schedule to incorporate daily walking. He demonstrates high self-efficacy and motivation to control his blood pressure and follow the SHAPP nurse's instructions to walk regularly.

#### *Summary of Barriers to Healthcare*

This section describes barriers to healthcare experienced by patients such as lack of money to pay for medicines, lack of access to healthcare from lack of health insurance, personal shame and embarrassment from the clinic staff discovering their poor financial situation, and lack of motivation to exercise. In total, 28 of the 29 patients reported a barrier to healthcare. For each barrier, 5 reported lack of access to money, 2 reported lack of previous access to healthcare, 3 reported missing appointments from embarrassment or family situations, 15 reported lack of motivation to exercise, and 3 reported fear of falling from exercising. To summarize, the clinic staff supported the patients in their addressing barriers to health care such as money, lack of access to healthcare, missing clinic appointments by compassionate care to their medically underserved and low-income patients.

#### *Experiences with Previous Healthcare Providers*

When I asked patients about their experiences at the SHAPP clinic, patients answered by comparing their current experiences at the SHAPP clinic to previous experiences with private physicians. I did not prepare a question about experiences with previous healthcare providers in my interview guide for data collection; however, this theme emerged as an overall trend in

my analysis of the interviews. Below are supporting examples from current SHAPP patients.

Nicole, a retired house cleaner compared her current experiences at the clinic with her experiences with her previous private physician:

Well, I, I, I feel like they [pauses] like I said I think they are concerned about monitoring my blood pressure history and getting me the proper medication to keep it under control. Just like she told me I thought I was having problems with itching with one of these but you didn't take it for 2 weeks why don't we get you back just take it regardless and I'm gonna bring you back in 6 weeks and we're gonna check it. So you know like the follow-up and the monitoring of it. Because when I was going to my [private] doctor, I would just say I need my blood pressure, I'll say this blood pressure medicine is making me cough but you kind [of] need to take it go on and take it for now. Now the 2, 3 times I been here and it's not been stabilized she keep bringin me back regular to keep it checked under. And I think that's good because I can take the medicine for 6 months and not even come back you know what I'm saying. And in 6 months cause she could tell me to take my blood pressure like the doctor said in between but because it's not stable she's having me come back on a more regular basis until we see what really works. If I'm doing what I supposed to be doing and if the medication is really working. You know when I come I mean it's better than I ever expected never been to a clinic before and I feel this is something really nice for this town. Yeah, it's more personalized care. It's more personalized care. [Before] it was kinda like a thing like you go and they take your blood pressure, your blood pressure's up give you your medication for 6 month prescription. You could take your blood pressure by going to a pharmacy or somewhere and take your blood pressure in between. But if unless it was out of whack you know [the doctor] just say continue taking your medications. And then it's time for your prescription they tell you to come back in. But nothing to see if it's up and down. And if it's only monitored

once a year or every 6 months sometimes you may not you know see that it, the medicine need to be changed or whatever you know.

Nicole remarked on how the nurses spent additional time to monitor her blood pressure versus merely giving her refills of her blood pressure medicines, from her previous experiences with her private physician. These actions display the nurse's warm, caring nature and careful attention to patient care in managing patients' blood pressure and these actions contribute to Nicole's high self-efficacy in controlling her blood pressure and continually visiting the clinic.

Julia remarked on the great improvement in care at the clinic compared to her previous private physician:

Everybody's nice. They have time and you know like everybody here when you come in I felt the front register I get greeted and then the nurse have time, well the nurse have time to talk to ya. And then like they got other patients you know well they have other patients but nothing like they in a hurry they got to run in and check you and get you your medicine and send you on your way. They take time to talk to you and talk to you about how you like cutting back on your smoking, cutting back on your drinking (chuckles), watching what you eat. They always do a good job. They always talk to me about stopping [smoking] well I don't in the day. They have asking well you need to stop [smoking], don't smoke at night. [Before my doctor] didn't have that much time you know. You know it's like this one doctor, had been a long time, and he looked like and tell me something you know I'm, I'm nothing like eating bacon and sausage and stuff you know I'm like I'm growing up my first head hogs we had. We was like I was trying to cut back then he just get like nasty he just get frustrated with me and stuff and say stuff and then I would say stuff back to him and (chuckles) oh man. But I don't like anybody to raise their voice at me you know nothing like that.

Julia noted the stark contrast between her experiences with her previous private physician

and her current experiences at the SHAPP clinic. She criticized her previous medical care and did not feel comfortable with her previous private physician in her clinic visit. These previous interactions with the physician may have contributed to her anger and low self-efficacy. At the clinic during the time I interviewed her, Julia felt strong rapport with the nurse and happy to express her concerns and follow the treatment to control her high blood pressure. Due to her strong rapport with the nurse, Julia continued to visit the clinic for her blood pressure treatment.

However, 15 of 29 participants did not relay any positive experiences with previous private healthcare providers. They may not have recalled their previous physician visits or did not wish to discuss their experiences with the researcher in the interview.

#### *Summary of Experiences with Previous Healthcare Providers*

Overall, the participants expressed sincere gratitude towards their treatment from the SHAPP nurse and dislike when recounting their experiences with previous private physicians. The participants recognized the high quality of care from the nurse's attention to their thoughts and feelings as a patient and genuine concern for them as a individual. With previous private physicians, the participants felt they were being rushed in the visit to obtain their prescription and leave before the next appointment time of the physician. Also, participants may have felt little or no rapport with their previous physician and uncomfortable in voicing their concerns as a patient about controlling their hypertension. With previous physicians, participants reported low self-efficacy in controlling their blood pressure but now seem to have high self-efficacy as a patient in the SHAPP clinic.

#### *Experiences with the Initial Diagnosis of Hypertension*

Another question I posed to participants to answer Research Question #1 was this: I want you to think back to when you were first diagnosed with high blood pressure. Can you tell me about that time in your life? (Appendix D). Examples of patients' answers are provided below.



Nancy, an uninsured nursing assistant, described her life at that time she was diagnosed: I didn't believe it. When I was first diagnosed with it you know I noticed that I been having headaches cause really I don't know anything about blood pressure you know. Too much. I kept getting headaches off and on you know and wasn't watching what I was eating. Just eating back then and wasn't thinking about eating a diet or anything. So when I went to the doctor you know it was a doctor she's passed away now. She was the first one who told me that I had high blood pressure. She said from what I see now but what I want you to do I'm gonna want to keep a record and she gave me some medication and I started taking the medication and so as I kept the on it, it was where it needed to be [to be higher than normal] you know so I guess I believe I had high blood pressure. Since I was, I was diagnosed with it I didn't wanna accept it at first because I was like "Ahhhhh I can't have no high blood pressure!" You know that's what I thought to myself.

Prior to her diagnosis, Nancy ate all the foods she desired without thinking of the future impact on her health, particularly her high blood pressure. She displayed low perceived susceptibility and Nancy recalled her lack of unawareness of the impact of her unhealthy lifestyle behaviors on contributing to her having high blood pressure. She expressed disbelief of the diagnosis because she was in denial about admitting her unhealthy lifestyles and her urgent need to change them in order to control her blood pressure.

Paula recounted the details of her diagnosis and life at that time when first learning about her hypertension:

I was working for this big company in New York City. And got up one morning – I used to take the express bus to work. I got up this morning and I was so dizzy, lightheaded, very lightheaded, you know but at, at the same token at that time I used to drink. Okay so I thought I was having a hangover. So I went to work taking Alka Seltzer and things like

that. So all day long, I, I usually like by 12 o'clock I'm okay. And I just, I didn't get any better. I was getting worse. And so we happened to have a physician that my company dealt with on the floor in the building I worked in. And so they took me there because I was, I was, I was out of it. I was gone. I think I was getting ready to pass out or whatever but anyway when I got upstairs my blood pressure took it, clock me in at 180/120 and he refused to let me go anywhere until he found out if he could get it to come down himself or long enough for me to get you know at least get home or other than that he was gonna put me in the hospital...so anyway that's when I found out that I really had to clock myself because I almost died. My eating habits were outrageous at that time. As I said I used to eat a lot of salt. Hot sauce, peppers, everything that a normal person [laughs] would pass up sometimes, but me I had to have it every meal, I used to put it – hot sauce on my eggs. You know, stuff like that. And the saltier something was, the better I liked it. And the salt did it to me.

Paula indicated a lack of education on high blood pressure and her unawareness of her unhealthy dietary behaviors. She displayed low perceived susceptibility. Her diagnosis and near death experience motivated her to learn to control her blood pressure. Paula's experiences demonstrated the need for more public health education efforts among low-income, low-educated populations on the prevention and control of high blood pressure.

Larry remarked about his life at the time of his physician diagnosis of high blood pressure:

Yeah I was it was once I had come here in Georgia. I've been in Georgia 13 years. And [pause] I, I, I, had a job as a quality assurance technician and [pause] I don't know I was having some problems um what I thought might have been sinus and, and I was having some headaches but it, it might have been because in my mind it was because of the plant I was in, I was working at a plant. And I went to the doctor's office and they told me that let me take your blood pressure and I had just [been] smoking a cigarette,

drinking a thing of coffee in the care and I come in and when they took my blood pressure they said your blood pressure's sky high. And again I'm not looking at the seriousness of it. It's like okay. And she asked me little pertinent questions. Do you smoke? And I said yeah. When was the last time you smoked? I said 10 minutes ago you know if that long. Do you drink coffee? Yeah. When was the last time you drank coffee? I said 10 minutes ago. I mean so they said you really need to let your blood pressure settle down. And again I'm not seeing how important it is and I had forgotten that high blood pressure played a part in my mother's death so I'm not really looking at the severity of this. So it wasn't until I think maybe about 3 years ago. I was having headaches and dizzy spells and and I was told then that my blood pressure was high and that I was gonna have to be put on blood pressure meds and so that's when I started at that time I was working I wasn't coming here to the clinic. But since that time like I said I'm not working and I couldn't afford my doctor so he suggested that I come here.

Likewise, Larry indicated his lack of awareness of the risk factors of high blood pressure and his apathy on practicing healthy behaviors. He displayed low perceived susceptibility at his doctor's office. Similar to Paula and Nancy, Larry's lack of concern for his health may have contributed to having hypertension.

However, some participants were unsurprised by their first diagnosis of hypertension and said how hypertension was in their family blood and was inevitable to happen to them. Larry says,

[My high blood pressure] might be hereditary. My mother had it and the majority of my family members, my siblings had it and so I, I suspect it runs in my family genes and, and our genetics but I mean I'm again it doesn't really faze me why, how come we had the fact is and they're giving me [medications] to help keep it contained.

Larry expressed his acceptance of his hypertension diagnosis and his awareness of the

prevalence of hypertension in his family history. He reported his belief that hypertension occurs in his family genes and the high likelihood of people in his family being diagnosed with hypertension.

*Summary of Experiences with the First Diagnosis of Hypertension*

Overall, patients reported a lack of knowledge of the risk factors of hypertension and awareness of the impact on their long-term health of behaviors such as a poor diet, lack of regular exercise, smoking, and high stress on their long-term health. Based upon the interviews, 15 of 29 participants reported that they had been previously unaware of the risk factors of hypertension and the negative consequences of their unhealthy behaviors. In summary, these patient accounts provide SHAPP clinic staff the foundation on which to educate their patients about hypertension control and provide medical care to lower their blood pressure. Also, the patients' experiences with the first diagnosis of hypertension provide a means of comparison to their experiences since their first diagnosis while attending the clinic.

*Experiences Living with Hypertension since First Diagnosis*

Another set of questions I posed to participants to answer Research Question #1 was this:

- 1) Tell me what your life has been like since you were first diagnosed with high blood pressure.
- 2) Tell me how you control your blood pressure (Appendix D). Patients related their experiences with changes in their diet, exercise, weight loss, learning stress management, and taking blood pressure medicines.

Paula discussed her changes in diet, but she said she struggles to increase her physical activity:

I have lowered my salt intake definitely. And sugar. Yeah I have moods of, of sweet things it's so I guess I'm a drinker they say when you, you drink sugar you know you have the, the taste buds for sweets. So maybe that's what it was. I just never was a sweet bud. And when I do get a taste for it I get it, that's the end of it. I don't continue to eat it you know. So my my diet, my attitude, my attitude definitely changed because as I said I

didn't take it serious that it was anything that bad. You know just something, something that the [private] doctors could get their money. You know. And I found out that it wasn't a play thing. That it could just well take you away from here as anything. So I didn't want that cause I still had to raise my children.

Paula recounted her urgent need to make the necessary lifestyle changes in order to prevent her early death and to continue to spend time with her children. Her perceived susceptibility was high and she reported high self-efficacy to improve her diet to control her blood pressure. She demonstrated the motivation to comply by following the changes as prescribed by the SHAPP clinic nurse. Paula's change in attitude has assisted her in improving her diet to control her blood pressure.

Hannah, an unemployed and uninsured patient, discussed the changes she made in her life:

It has changed because I have had to change my lifestyle you know, the way I eat and you know my whole outlook on life. Because a lot of people don't realize that high blood pressure is a silent killer, if not treated and I know this. And it can cause you to have I mean your kidneys, if not treated your kidneys to shut down and everything and have to go on dialysis. My older sister was on dialysis like for years before she died. And I saw what this did, did to her you know. I wanna try to do the right thing cause I don't wanna be in that situation. And I know it can cause strokes. My sister that's 4 years younger than me, because of the high blood and everything last year she had uh (pause) open heart surgery. She had several heart attacks in the hospital because of high blood pressure. And I know what it can do to your body. I know firsthand. I mean all that fried fatty food and stuff, I mean every once in a while I might eat some. As like an everyday thing, I know that exercise is that's the number one things. And it relieves stress for me. You know if I'm out walking.

Hannah was tremendously affected by her sister's death from complications of hypertension and heart attacks, increasing her perceived severity. Her sister's struggle to survive in the hospital, her refusal to control her high blood pressure, and her not making lifestyle changes has motivated Hannah to make important changes to exercise and improve her current diet. Her sister's death served as Hannah's cue to action to control her blood pressure. Thus, Hannah completely changed her previous lifestyle and her entire approach to living a healthy life.

Nancy, a nursing assistant, discussed her lifestyle changes at this point in her life:

I help myself. I help myself. I watch [my blood pressure] you know and what I eat and things that I do and not being stressed out. Cause stress can contribute to high blood pressure. I mean you know being stressed and you're worrying and your mind is going here and there. You know I find it out you know, that cause your blood pressure to go up. Stressing. When I was going through a divorce that [was] my biggest time of stress. Yup. I was going through the divorce. Well since I changed my whole life I don't let stress get to me. You know. I pray about stress now. I don't, I don't just let it bother me. I don't let stress get to me you know. Yeah. Get used to it. I don't let it get to me. I realize you know that I was endangering my life by letting stress get to me. So I can't let it get to me. Cause I don't, I don't let stuff get to me anymore. [My family and friends] already know cause they tell me "Oh you don't eat nothin anymore. You're not listening, Ma." You're losing weight. They already know. (laughs) They already know. They already know my kids too. They know, they noticed I don't eat the things I used to eat. They noticed that, they noticed that. They already know.

Nancy discussed the powerful impact of her divorce on her health and its contributions to the high level of stress she endured. She reported high self-efficacy and high motivation to comply with the clinic nurse's instructions. She realized that she does not want the stress to inhibit her ability to control her high blood pressure. Her family and friends have noticed the

changes Nancy has made in her life; however, she did not feel influenced by comments from others as she strives to control her blood pressure. She incorporated prayer and spirituality into her life as she is successfully managing her stress levels to lower her blood pressure.

Harry also remarked on how he sees the importance of controlling stress in his life:

Stress can cause [high] blood pressure and it can come from a lot of things. It can come from problems at home or I've seen people that's what a lot of road rage comes from and a lot of people they cut have road rage 9 times out of 10 there's a blood pressure problem there somewhere. And the best way I know to control it once it hits you is to go outside the door rather than argue with the person, say what you gotta say turn around and walk out the door till you cool off then you can handle the situation a lot better. Person stressed out can't handle no situation. Because if I get too stressed out I just go out the back door and walk up the sidewalk. Walk up the side of the store walk right out there in the front till I cool off and then I go back in there and get my work done.

Harry noted on the influence of a multitude of stressors upon high blood pressure, based upon his own personal experiences. Harry's health and work productivity deteriorated from his uncontrolled stress and inability to control on his blood pressure. Thus, he learned stress management techniques which improved his work productivity and his blood pressure control.

Joe, a retired hospital orderly, talked about his lifestyle changes:

Like I say it's that I just got more dedicated with taking [my medicines] and so once you get started taking it you just come easy. You know. You take it more seriously. Yeah you know that as you set a time to take it and you don't skip and miss a dose you know they're important and not do that because for instance like for me I had ran out. They tell you don't skip, skip a dose because of the next dose you know just wait until then but not skip another day or something. I feel like you need to keep it in your system. The

[nurses] frighten you by you know saying it can be serious if you not taking them your blood pressure I don't ever remember running out and not having any to take. Oh yeah like I said I figured I take my walking as exercise and my uh diet. I'm not, not on a salt restricted diet but I watch my salt intake like fast foods and potato chips and stuff like that. I, I will eat them but it's in a moderate amount, very. I try to limit it salt and I would I would always use the little sodium in cooking and everything.

Joe described the great improvement in his personal dedication to control his blood pressure. He indicated high motivation to comply, high perceived severity, and high self-efficacy to manage his HTN. Joe's experiences suggest his intrinsic motivation rather than reliance on other people around him to control his blood pressure. He was scared of the serious consequences that could occur from not taking his blood pressure medicines, and thus he was motivated to comply with the nurse's directions.

On the other hand, four participants reported difficulty adhering to lifestyle changes and controlling their high blood pressure since being first diagnosed with hypertension. One example of noncompliance is Katie's story below:

The nurse say, "You're blood pressure is through the roof" and then she sit me down in the chair and she told me about the dietician, you need to lose weight, you need to exercise, you need to do this and you need to do that and all that stuff that she told me I did. I, I never felt like that but nothing that she told me that, that I didn't do it. And so when I came back I was coming like every week cause she was taking my blood pressure every week. But when I came back my blood pressure pretend, pretend was going down. So she stopped fussing so much about it and she asked me which I told her yes but I did walk but I did not follow the diet and I didn't. I couldn't done a lot better than I have. I didn't follow the diet but I go walkin for the exercise but I never followed the diet, I couldn't. Because the stuff that I didn't like. The stuff they told me to eat. It was like



crackers, saltines, and a salad. I think it was a, a certain time of day I had to eat this stuff and by bedtime they wanted you to eat fruit, apples, and I don't think it was bananas. It was like apples or either oranges or something like that. But anyway I didn't do it.

Katie explained her noncompliance and struggles to follow the diet as prescribed by the nurse. Katie believed that the diet did not accommodate her food preferences and she did not adhere to eating a balanced diet with whole grains and fruits and vegetables. She struggled to control her blood pressure which was concerning to the SHAPP nurse during her clinic visit.

#### *Summary of Experiences Living with Hypertension since First Diagnosis*

Overall, the patients were highly satisfied with controlling their blood pressure since their first diagnosis. In summary, 26 of 29 patients reported positive lifestyle changes to control their blood pressure. These patients' success with controlling blood pressure also complements the caring and compassionate nature of the SHAPP clinic staff to educate patients about blood pressure control and to provide positive social support to patients as they work to maintain their blood pressure control, discussed in a previous section of this chapter.

#### *Experiences Changing from Noncompliance to Compliance*

This theme is an answer to Research Question #1. I did not prepare a question on changing from noncompliance to compliance in my interview guide, however this theme appeared as participants discussed their experiences in the SHAPP clinic. Below are examples of accounts from participants illustrating this theme.

Harry, an uninsured patient, described his change from noncompliance to compliance: The first time okay I heard about okay they had the clinic here for high blood pressure and I had a friend of mine that came and they was telling me they got their meds, how cheap they got their meds and stuff like that. But it was the time, I guess it was me like a person that's on drugs they say they're not now you know they are. I knew there was something causing me to have headaches. And I didn't search it enough to find out

whether it was in my family from my father and mother. I would have headaches to the point where I would almost black out. So I made up my mind to come and see what the program was and when I got here I did not wanna listen to [the nurse] because I was doing everything I wanted to do. I was drinking, smoking, a person with high blood pressure, how can they do all these things? Had been in [the] military as old as I was but something was causing my head, my blood pressure to go up. Me dumb and didn't realized it and that's the reason I didn't like it cause to me someone was telling me something that I did not wanna hear. She knew what it was and I didn't wanna take I didn't wanna accept it and she had to prove it to me in the physical examination. And the EKG everything that they showed about this being high and this should be like this – That's the reason why I didn't like it. She was telling me something I didn't wanna hear. And see I heard the myth about they said all Blacks have high blood pressure. I was determined to say I'm not gonna be one of these that's wrong that was the reason say why I didn't like. But it turned out to be the best of my benefit because this is what I meant by that.

Harry explained that his initial noncompliance when he first visited the clinic was due to his refusal to accept his diagnosis of high blood pressure and his lack of desire to change his lifestyle. Unaware of the consequences of his unhealthy lifestyle and the risk factors of high blood pressure, he allowed his physical health to worsen as time passed. Although the nurse attempted to explain to Harry the severity of hypertension and the consequences of uncontrolled hypertension, Harry refused to accept the nurse's instruction, suggested a lack of self-confidence to improve his unhealthy lifestyles.

Whitney also discussed her change from noncompliance to compliance, beginning to take her blood pressure medicines as instructed by the SHAPP nurse in the clinic:

Well I got upset [when I was first diagnosed] and I couldn't figure out why I had blood pressure problems. I really got upset about it cause I didn't wanna take my medicine. I found out I couldn't do without the medicine each time I had to go and didn't take it, my blood pressure would be sky high. It shot up then I realized I had to take it. I had to adjust to it. But there was a lot of times there was times where I was just forgetting them cause I realized I gotta, gotta have them so I started taking them. Tried to take them and make sure that I had done what I needed to do. Cause I didn't wanna get sick and have a stroke and get to be helpless. Like I've seen with a lot of people. Had happened to a lot of people I know.

Based upon her experiences, Whitney learned her lessons about the purpose of taking her blood pressure medicines. Previously she did not fully understand her high blood pressure condition and was not motivated to take her medicines. However, with the knowledge of the consequences of uncontrolled hypertension, she felt empowered and displayed high self-efficacy to take her medicines to control her high blood pressure unlike the other people in her life who had failed to do so.

Joe recounted when he first was diagnosed with high blood pressure and changing from noncompliance to compliance:

Oh I believe it happened back in the 70s I think. And so I first found out I had high blood when I donated blood and once I donated blood somewhere I was working at. Once I went to get it, I had been giving it all along, once I give it one time the nurse told me I had high blood pressure and nobody ever told me that before. And so she told me to check with my doctor and so I was. He put me on blood pressure pills medications so when I was younger I didn't take it seriously you know. So then I wasn't taking them. I wouldn't take them until eventually my doctor he had to get serious with me, get to make me feel stupid and you don't know the meaning of

blood pressure and he said you not stupid will you take them? And then on I take them because I was serious in taking them. I was young then and didn't understand it what the results could happen to ignorance to the fact that you know you know what you know about blood pressure and high blood pressure and that you were in denial of it. I basically got serious with it and been taking it ever since [chuckles]. Because [before] I felt like blood pressure you know is it wouldn't not that it, you didn't know the of it and so I didn't feel no symptoms or nothing like you say, you being young and thinking that oh I didn't need to take medications and you. And uh you're not it's not like a pain medication it's that you didn't know that blood pressure you didn't know, you see, you didn't feel the reason for taking it which I guess had it then and didn't know it. It was, I started off with a severe blood pressure because I knew it and [my doctor] explained to me that it was in the family line and something you just can't get around cause on my mother's side of the family it runs real and you know blood pressure and all those siblings and everything and that's why all my siblings and everything.

Again similar to the experiences of Harry and Whitney, Joe previously had not seriously considered the consequences of having uncontrolled hypertension and displayed his low perceived susceptibility. Joe's ignorance of his diagnosis led to his decision to not take his blood pressure medications. When his private physician told him of the severity of his condition, Joe finally decided to comply with his instructions to take his blood pressure medications regularly.

Although total compliance is desired in a patient sample of hypertensives, 4 of 29 participants reported as non-compliant with their blood pressure medications and lifestyle changes. Lisa discussed her experiences with noncompliance:

I'm concerned because I have high blood pressure myself I uh I seem sometime can't keep it under control. I haven't made any changes. Cause I have, just hadn't thought about that. Making no changes. I didn't needed to. [I could] get up and be more active.

Just don't sit around and, and wonder my mind and pity pat just like I tell my sister. Get up and you know do stuff. I could use a friend to help me along. Well I'm gonna tell, I'm gonna be honest wit ya, I'm not eatin the food I'm supposed to eat. I'm eating a lot [of] fried food. Most like I try to eat vegetables, not everyday. A lot of green vegetables I don't eat everyday. Water. I don't drink water like I should. Eat cookies. Like cookies. Sweets. Ice cream and cake. Really it's my opinion. I think that it's not that important because I made no changes until I have to get well something that really, really, really gets me knowing, knowing that I have to do this.

Lisa reported her struggle of adhering to her diet as advised by the SHAPP nurse. Although she was aware of her unhealthy behavior, she does not have the high self-efficacy and motivation to improve her health behaviors to control her blood pressure. Perhaps she was unaware of the sources of social support around her or felt uncomfortable asking other people in her surrounding for support.

*Summary of Experiences Changing From Noncompliance to Compliance*

Overall, the patients reported changing their initial noncompliance and discomfort with the hypertension treatment and the SHAPP clinic staff to a full commitment to lowering their blood pressure and following the clinic staff's instructions. In summary, 13 of 29 patients reported that they became compliant while attending the SHAPP clinic. Patients recognized their denial to accept their hypertension diagnosis, lack of knowledge of the risk factors of hypertension, and lack of motivation to make the lifestyle changes to lower their blood pressure. These experiences with compliance support the importance of the nurse's compassionate nature, and willingness to talk with patients in a gentle manner, and treat them as individuals rather than as only people with a disease to be cured.

### *Summary of Themes from Research Question #1*

The following themes are summarized from previous sections of this chapter. The patients recalled their positive experiences attending the SHAPP clinic and interacting with the clinic staff. Their praise for the clinic supports their high satisfaction with the medical care they received from the performance of the clinic staff. In terms of barriers to healthcare, the patients described their lack of money to pay for clinic visits, lack of access to care from the lack of health insurance, missing clinic appointments, lack of motivation to exercise regularly, and fear of falling from exercising. Prior to their diagnosis by their private physicians, patients were generally in denial of having high blood pressure, showed a lack of motivation to change their lifestyle behaviors to lower their blood pressure, and a lack of education about the risk factors of hypertension. Patients discussed the positive lifestyle changes they have made to lower their blood pressure such as improving their diet, lowering their salt intake, improving their frequency of exercise, and lower their daily stressors. Finally, the patients described their changes from noncompliance to compliance while attending the clinic and their satisfaction with the support from the clinic staff.

### *Research Question #2: What are the differences in the lived experiences between Whites and African Americans?*

For Research Question #2, no differences were found between Whites and African Americans. The participants did not discuss any personal experiences with racism or discrimination. The desired sample of an equal number of Whites and African Americans was not obtained. These particular issues surrounding this research question are addressed in more detail in the discussion section of Chapter 5.

*Research Question #3: What are the differences in the lived experiences between men and women?*

This question was addressed in my analysis of the interview transcripts as I noted the differences in the experiences between male and female participants. Men and women expressed similar views on the previously mentioned themes; however, differences appeared between male and female experiences encountering stress. In terms of stress-related questions, two questions posed to patients were:

- 1) Do worries, hassles, or everyday concerns affect how you control your blood pressure?
- 2) Are there things in your life that can make your blood pressure go up?

Participants responded by discussing their experiences encountering stress and the gender differences are noted in examples below.

Tamyra, an uninsured patient discussed her stressful life:

I'm the oldest of four girls and I don't know what they jealous of. I don't have nothing but they just seem to be sibling rivalries you know what I mean? I have to deal, deal with stuff like that. My momma she go along with their mess and that is very stressful. It's always been like this. It's always been like that since I see when I was I got pregnant at the age of 15. And had to really raise my two children by myself. We had a hard time on welfare and now one of them's an RN the other one is in college seem to be envious of it. You know they so used to being on the welfare but we strived to get better all them years and got better you know. I got a job, they went to college and I have to deal with all that kind of mess. It just ridiculous. Yeah and I don't have nothing. I don't have a dime. They doing they live better than I do. They houses are paid for but you know they still don't wanna see me with nothing. Well what had run up my blood pressure higher up than anything in my life. I bought a house in my mother's name and two years before it was paid off she took it. I lost 35,000 and almost died. I was 40 something years old and I had

to start all over. Greed. Pure greed she got ready out making money it. Greed. I didn't know she was that kinda lady. I trusted her. You know your momma. She always said I'm gonna help you out and get a house you know. She well really got money off it. She been getting money off it 10 years. I think living with that had really stressed me out. Yes it's been 10 years ago and I still just can't believe my momma done me that way. And she don't think she did nothing wrong. Oh God she didn't think she did nothing wrong. She, she making money off it. She done convinced herself that she had every right to do it you know.

Tamyra discussed the powerful influence of stress from her family troubles in her daily life that influenced her current psyche. Her powerful emotions surrounding her family situations contributed to her high stress levels which she believed influenced her having high blood pressure and her difficulty in controlling it.

Paula also described the impact of stress, in the form of anger, in contributing to her high blood pressure:

Because if I stop taking my medicine, all I have to do is get angry. Good and angry and my blood pressure shoots up to the sky [laughs]. You know. Ah [chuckles]. It's not much really. It's not much. But to be honest with you it's usually paying bills and when my children do stupid things uh sometimes I get angry with myself some, because of something that I've done you know I'll get angry with myself but that doesn't carry on like it does like if I'm actually like you and I are fussing back and forth and my blood pressure goes up one of these things but if I, if I stay quiet you know go back, go back at home, home. Usually what I try to do when I do get angry and upset like that, I try to, I go and sleep. I lie down just try to be quiet and when I wake up I'm better.

Paula discussed the impact of anger upon her inability to control her blood pressure. In her life, money and her children have a powerful impact upon her psyche and on her inability to manage



her daily stress. She acknowledged her need to step away from a stressful situation and be alone in order to lower her anger and prevent her high blood pressure from occurring.

Similar to Paula, Erin, a part-time cafeteria worker discussed the stress she endures with her adult children:

Worries or hassles leads to things around you that make your blood pressure go up.

Worry. Stress. Stress'll kill you. Well sometimes I get stressed about my children. Your kids can really get on your nerves. [pause] Worst off when they're grown that they is when they're kids. You can control them better when they're kids. Once they get grown it's hard to control them. You really can't control them. You can say what you wanna say. They, they might take it another way or they pay not pay you no attention at all.

I, I, I, I got, I got one that's been stressing me out.

Erin's frustrations with her children result from their erratic and impulsive behaviors and their failure to meet her expectations as a parent. She wanted to see them become successful in their work and life, yet she was frustrated when they became overly independent and failed to listen to her sincere wishes as a concerned parent. Thus, these family stressors contribute to her high blood pressure.

Harriet discussed the stress she experiences in her job as a janitorial supervisor:

Well you know like I say it's the type of facility that I work in so there's always some stress that's going on. Also I supervise 10 other people and so that brings on a level of stress there also I just recently we got a new director of janitorial and I guess I would say that he has this idea of he can come in and he can come in and change all things and make all things better and his way is the only way so you know there's, there's kinda of a level of stress there because he's the type of person that it's like this and not too much you can really say so. That brings on some stress for me because I was there and I know the workings of this facility better than any not say better but more than he does.

Harriet's health was impacted by her work environment, increasing her stress levels and her blood pressure. Being under the direction of the new janitorial director, Harriet felt powerless because she was internalizing her stress rather than verbalizing her stress about working under her new director. Perhaps her internalization of her emotions was impeding her control of her high blood pressure.

On the other hand, Billy, a business owner and part time college student, discussed his life without stress:

Mmm most of the time, I don't, I don't have a time where I, I might vent occasionally but most of the time I don't have anything like that. My mom several years ago was, talked to her on the phone had a tough day and she said are you complaining? And I said I stopped for a minute and said no mom I'm just venting for a minute. I'd be okay I said. My life's pretty full. My life's pretty good in as much as you, there's ain't much complaining in me. I'm that type of personality some people can't deal, I just say do it myself or that type of thing. I'm not too much into excuse things. My kids generally mirror, mirror me in that. Whenever they were little, if one of them said that's not fair the other would we'll say one of them say that's not fair. The other two would go life's not fair. And whenever I, I had situation where the people put them in a bed together every night and we're talking about making a decision and so how you gonna make that decision? And the oldest one who was about 10 years old three years apart and she was 12 years old. She said I'm gonna weight out my [pause] I'm gonna look at the situation and weight out all my options and I'm gonna select the thing that's gonna hurt me less. My kids speak. You know. It just made the big lump in my throat coming. I must be doing pretty good here!

Billy talked about his pride in his life and his success in raising his two children. He learned this demeanor from his mother during his childhood which later translated into his adult life.

He approached life with great optimism and his demeanor has helped him to control his stress in life and his high blood pressure.

Larry talked about the calm and peace in his current life, although he is unemployed and uninsured:

I'd be lying that I was stress free but most of the time I am living a stress free life I let very little upset me or throw me off track. It's like I got an inner peace that's just out of this world. I think there's a lot of people that envy me for not getting bent out of shape for little things. But I mean this moving cause I'm moving from one place to another. Now that's stressful. I don't like moving so that would maybe be the most stressful thing that has happened to me in quite a while. I try to sit down uh relax I'll pray and then just try to think the whole situation out. Maybe what it is that is stressing me out. You know like I know there's good stressors and bad stressors you know. But generally just kinda of taking time out to sit down and I do, I'll, I'll say a little prayer it's called the serenity prayer and it seems to work for me.

Larry remarked on his inner peace which helps him weather the stressors throughout his life such as his current unemployed and uninsured status. He acknowledged the stressors in his life but possessed the inner strength to overcome them with his faith in himself and prayer. Thus, he utilized this inner peace in not only managing his stress but also controlling his blood pressure.

Joe discussed his mindset to approaching stress in his life:

I'm a person that stress don't you know I don't get stressed out that much. Some things come on I could be stressed out. I guess about it like you I believe in going to church and you know like, like some even say you just leave it that way and I believe in God and I believe in having stuff like that and I don't, I'm not a person that easily gets stressed out. And you know, you know I guess at a certain you know not to stress out that much. say not stressed out. You just get it in your mind. I do and just say you won't, you don't,

you don't let it bother something in your mind, you can't get out try to think about something else. A time, a better time.

Similar to Billy and Larry, Joe did not allow his environment to influence his perception of stress and his positive outlook on life. He had a certain mindset in which he refuses to succumb to stressors in life which helps him to avoid a pessimistic attitude and thus live a healthy lifestyle to control his blood pressure.

Stanley, an unemployed and uninsured patient, described his life free of stress:

Oh no. Trying not to let too much bother me. When I got out of work, I didn't let that bother me. Just stay calm, cool laid back, that's about all I do. I don't you know I don't get all upset and frustrated like a lot of peoples does. Oh what I do to relax. I like to get out there on the porch and sit and doze off and go to sleep. I get so sleepy out on the porch. That's what I mostly do in the afternoons.

Stanley had an approach to life where he chooses to stay calm and relax during difficult times. He did not allow the stressors in his environment to dominate his life, and his carefree attitude helped him to lower stress in his life and control his blood pressure.

Although the women in this study reported greater experiences of stress than did the men, some women reported little or no stress at all in their daily lives, similar to the men's experiences. For example, Julia remarked about her approach to life and handling stress,

I don't well worry. Yeah you know I like to sit back and you know I sit back and be quiet and say nothing and you know that's meditate and it go away. I find me a something like to look at on tv then forget about it. Cause like I don't worry about it. Like worry, like worry about stuff. No because they ain't go fix anything. They ain't gon make it better. I might get like its need be like this and then I'll get over it. I done forget about it.

Julia expressed her desire to live a life in which worry and anxiety do not occupy her daily

thoughts. Thus, she believed she is content in her life, relaxed, and successful in controlling her blood pressure.

#### *Summary of Differences in Experiences between Men and Women*

The majority of themes from the first research question were commonly reported by both men and women. However, to address the second research question, men stated that less stress occurred in their lives than the women did. Women reported that stress occurred more often in their lives than men did and believed that stress in their lives contributed to having high blood pressure and their ability to control it. Seven of 9 male participants reported low or no stress in their daily lives, while 18 of 22 female participants reported high stress in their daily lives. These accounts may demonstrate that while stressors in male and female participants' lives exist, the perceptions of these stressors and situations may differ between men and women.

#### *Summary of other findings*

In addition to the research questions presented in this chapter, I asked additional short answer questions to assist with establishing rapport with the patient during the interview setting. These questions are presented below and organized in the following manner: clinic and medical care, diagnosis and treatment, blood pressure control, diet and exercise adherence, blood pressure medicines, and daily stressors.

Table 18 is a representation of the count of the short answer questions which the participants answered in the interview. All 29 participants reported they were getting the proper medical care, they believed what the nurses were telling them, and they were satisfied with the medical care they are getting. Only 2 of 29 participants reported they experienced problems getting to the clinic and were reliant on transportation from a child or a grandchild. Twenty four of 29 participants suggested no necessary changes or improvements to the clinic. Five of 29 participants recommended possible improvements such as water in the waiting room, a walking group, a support group with other active patients, and increased funding to hire more nursing

staff. None of the 29 participants reported no other improvements for the clinic to help them manage their blood pressure, and all agreed that they are responsible for controlling their blood pressure.

In terms of diagnosis and treatment, the following results are reported. All 29 participants reported that blood pressure is a problem that can hurt them, believed that blood pressure should be treated, and were aware of the complications of high blood pressure. Twenty six of 29 participants were serious in following their blood pressure treatment. Twenty five of 29 participants were concerned that they have high blood pressure, and 25 of 29 participants \ reported they do not feel any different than others with high blood pressure. All 29 participants correctly identified the complications of high blood pressure, and 25 of 29 participants reported that they are scared of these complications of high blood pressure.

In terms of blood pressure control, 26 of 29 participants reported that they are controlling their blood pressure. These 26 participants reported that they control their blood pressure by taking their prescribed medicines, lowering their daily stress, and maintaining a balanced diet and regular exercise. The other three reported that a higher power controlled their blood pressure and not themselves. Also, 20 of 29 participants reported that nothing and no person in their life helps them to control their blood pressure. Eight of 29 participants reported that a medicine box and a spouse, child, or grandchild helps them to control their blood pressure, serving as their cue to action for blood pressure control. Also, 25 of 29 participants reported that they are following their appointments as directed. Reasons for coming to the clinic include compassionate care from nursing, friendliness of clinic staff, and making positive lifestyle changes to lower their blood pressure. Reasons for missing appointments included lack of money to pay for the clinic visit and feeling shame and embarrassment about admitting their poor financial situation to the SHAPP clinic staff.

The following results focus on diet and exercise adherence. Twenty five of 29 participants reported they were following their diet. Family and work stressors were reasons for not following their diet. Also, 18 of 29 participants reported that they are exercising regularly to control their blood pressure. Reasons for not exercising include lack of motivation, lack of time in their busy daily schedule, sedentary work environment, lack of social support from family and friends to exercise, and no safe neighborhood to walk outside of their house. Twenty five of 29 participants reported they had a weight problem; however, 20 of these 25 participants reported attempting to lose weight and were motivated by their desire to live a healthy life, see their grandchildren grow older, and the positive social support provided by the SHAPP clinic staff.

The following results focus on taking blood pressure medicines. All 29 participants reported using their medicines as they are prescribed. To take their medicines every day, 15 of 29 participants used a medicine box to take their medicines as prescribed, serving as a cue to action for blood pressure control. Also, 15 of 29 participants received positive social support and encouragement from a family member, friend, or coworker. However, 14 of 29 participants did not need a medicine box or reminders from family and friends. All 29 participants stated they did not need help from others to take their medicines. Twenty seven of 29 participants reported no problems with their blood pressure medicines. All 29 participants reported they were not scared of taking their medicines. Twenty six of 29 participants reported no side effects from taking the medicines. Three of 29 participants reported low sex drive as a side effect from taking the blood pressure medicines. Three of 29 participants reported the cost of the medicines was a problem.

In terms of stress-related questions, the following results were reported. Twenty of 29 participants noted that the SHAPP nurse, staff, and family help them control their blood pressure. Twenty two of 29 participants reported that things around them that can influence their blood pressure control. Twenty of 29 participants reported that they do not talk to family or friends about their blood pressure. Nine of 29 participants reported that they do talk to family, friends,

and coworkers about their blood pressure in person and on the phone. Fifteen of 29 participants reported that they are able to control their own stress and described using meditation and prayer to manage their stress. Twenty six of 29 participants reported there was not anything they were unable to do in their lives because of their blood pressure, with three participants noting changes in their lives such as no longer eating high sodium foods and fried, fatty foods. Twenty seven of 29 participants believed they have high blood pressure because it was inherited from their family members. Only two participants discussed that in addition to family history, lifestyle choices such as poor diet, lack of exercise, and high stress contributed to their blood pressure. All 29 participants did not blame any other person for being diagnosed with high blood pressure.

Table 18

*Participant Responses to Short Answer Interview Questions*

Question	Yes	No
<b>Clinic</b>		
Do you think you are getting the proper medical care in this clinic?	29	0
Do you believe what the nurses are telling you?	29	0
Are you satisfied with the care you are getting?	29	0
Do you have a problem getting to the clinic?	2	27
Are there improvements or changes in the clinic you would suggest for better care?	5	24
Is there anything can the clinic do better to help you manage your blood pressure?	0	29
<b>Diagnosis/Treatment</b>		
Do you believe your HBP is a problem that can hurt you?	29	0
Do you believe your high blood pressure should be treated?	29	0
Are you serious in following your blood pressure	26	3



treatment?

Are you concerned that you have high blood pressure?	25	4
Do you feel different than other people who do not have HBP?	4	25
Are you aware of the complications of HBP?	29	0
Control/Management		
Do you control your blood pressure?	26	3
Are you following your appointments?	25	4
Are you following your diet?	25	4
Are you exercising regularly?	18	11
Is there anything that keeps you from following your diet?	4	25
Do you have a weight problem?	25	4
Medications		
Are you using your medicines like you should?	29	0
Do you need help so you can take your medicines properly?	0	29
Do you have any problems using your medicines?	2	27
Are you scared of taking your medicines?	0	29
Do you have a problem with the side effects?	3	26
Is the cost of the medicines a problem for you?	7	26
Do you talk to your family and friends about your blood pressure?	9	20
Are you able to manage your stress?	15	14
Are there things you want to do but cannot do because of your blood pressure?	3	26

### *Summary of Overall Findings*

In conclusion, several overall themes were identified from analysis of the transcripts. The participants noted that the nurses valued and respected them as individuals and took the time to answer their questions and concerns about their health and how to control their high blood pressure. Prior to attending the clinic, the participants ate a poor diet rich in salt and fried foods and failed to exercise regularly. Participants compared their current experiences at the clinic as much better improved than their previous experiences with other private physicians in terms of their hypertension control and management. Previously, participants noted how they were unaware of the risk factors of hypertension and the negative consequences of their unhealthy lifestyles. Now being an active patient in the SHAPP program, the patients noted they are fully knowledgeable on the risk factors of hypertension and how to manage and control their blood pressure with weight loss, regular physical activity, and a proper diet. Also because of the nursing staff's compassionate nature, the participants feel motivated to control their blood pressure and are fully committed to complying with the nurse's instructions to take their blood pressure medicines as prescribed. In comparing White and African Americans, no differences in experiences were found. In comparing men and women, only experiences with stress among family and co-workers differed between men and women. The male experiences suggest a calm and relaxed demeanor to their lifestyles, with little internal pressures resulting from the outside world such as being unemployed or not having money. However, the females felt overwhelmed with high stress from raising their children, communicating with coworkers, and the lack of finances and health insurance.

In the final discussion section, the results are applied to the field of hypertension, and the results are compared and critiqued according to previous studies in the hypertension literature. Study limitations are stated, including those of the researcher, and recommendations follow to address these limitations when conducting future studies. Implications are provided for practice,

research, education, and policy. Also, lessons learned during the study and unexpected experiences and themes are identified, ending with the final conclusion.

## CHAPTER 5

### DISCUSSION

This chapter discusses the findings of this study and applies them to society, research, and practice. This chapter is organized into the following sections: 1) discussion of the Chapter 4 results addressing the three research questions in Chapter 1, 2) study limitations, 3) researcher's unexpected experiences, 4) lessons learned from the study, 5) unexpected emerging themes, 6) implications for clinical practice, research, education, and policy, 7) future research directions, and 8) final conclusion.

#### *Discussion of findings*

*Research Question #1: What are the lived experiences of African American and White older adults diagnosed with hypertension?*

This study provides deeper insight into the experiences of African American older adult patients attending a clinic at a Health District's county Health Department in a southeastern U.S. state. Previous SHAPP reports, as stated in Chapter 2, contained demographics of active patients and rates of compliance with blood pressure medications. These patients' stories illustrate their understanding of their blood pressure, impression of the care they received at the clinic, and their successful experiences managing their blood pressure as active patient. Their positive descriptions of their interactions with the nursing staff validate the high compliance rates in the 2007-2010 annual SHAPP reports (Appendix Tables 3 – 5).

This study's results are similar to a recent qualitative study on the same program in another health district (Constantine et al., 2008). Constantine et al. conducted a mixed methods study in a health district interviewing physicians, nurses, and patients about their experiences

with the program. All participants described the great success of the program in reducing noncompliance and improving blood pressure control rates among patients while enrolled in the state program. These positive patient accounts in this study, as well as high compliance rates, are a testimonial to the great success of the clinic over the years. In this study, one explanation for the positive experiences of the patients with their blood pressure control is their high level of social support from the nursing staff and those in their living and working environments. Another reason is the availability of low priced blood pressure medicines. However, this study differed from the Constantine et al. study by using a predominately African American sample, 55 and older age group, and qualitative methods in design.

#### *Clinic Experiences*

Social support is an important component of the participants' experiences living with high blood pressure and their willingness to be compliant. At the SHAPP clinic, patients can openly discuss their experiences, daily stressors, dietary problems, and exercise issues with the nurse in the clinic who can then offer positive reinforcement and suggestions for improvement to each patient. Social support, as theorized in Chapter 2 with the Theory of Reasoned Action/Planned Behavior, particularly from the clinic nurse and staff, family members including grandchildren and children, neighbors, coworkers, and friends, provides a positive environment for the clinic's patients to enhance their self-efficacy to control their blood pressure and make the necessary lifestyle changes to improve their health and well-being. This finding is supported by similar results reported in the medical and nursing literature (Bosworth, et al., 2003; Boutain, 1997; Boutin-Foster, et al., 2007; Shah & Cook, 2001). However, this study differed from previous studies in that the theoretical constructs such as self-efficacy, perceived barriers, and perceived susceptibility are identified in the participants' accounts versus in survey questions.

This positive, supportive environment in the clinic helps patients to feel self-satisfied and valued as individuals, which may contribute to increasing their self-efficacy and empowering them to control their high blood pressure.

In addition to social support, another explanation for the patients' positive clinic experiences in the SHAPP clinic is self-efficacy and empowerment. Self-efficacy and empowerment were a main component common to the participants' life experiences in this study. Self-efficacy is defined as the belief or confidence in oneself to achieve a certain task or behavior, such as blood pressure control (Bandura, 1977). Active SHAPP patients with high self-confidence described how they controlled their previously high blood pressure to normal (<120/80) by taking their prescribed medicines and through lifestyle change. Many patients remarked that the nurses can only give them the medications and advise them about diet and exercise, but ultimately the decision to follow the regiment lies in the patient's own hands to control their blood pressure. This pattern is also a common finding across previous studies in the literature (Burke et al., 2008; N. M. Clark & Dodge, 1999; Finset & Gerin, 2008; Jokisalo, et al., 2001; Maloni, 2007; Martin, et al., 2008; R. M. Peters, et al., 2006; Viswanathan & Lambert, 2005). On the other hand, this study differed from these previous studies by using qualitative methods in design and focusing on the age group of 55 and above. In this study, the participants' high self-efficacy has likely contributed to their compliance with their blood pressure medicines as well as successfully incorporating healthy lifestyle changes into their daily routines.

The participants praised the nursing staff on the high quality of care and the compassionate attention they provided. Many patients rightfully perceived that the nurse and clinic staff treated them as well or better in quality compared with previous private physicians. The SHAPP clinic staff's practice of holistic care has proven successful with the patients in this

study's sample. Notably, participants stated how much improved the provider –patient communication was from their perspective. Previous qualitative studies also note the importance of the interactions during the provider –patient visit and the quality of communication between the two from the standpoint of patient compliance (Bane, Hughes, Cupples, & McElnay, 2007; Boutin-Foster, et al., 2007; Cooper, 2009; Fuertes et al., 2007; Gascon, et al., 2004; Higginbottom, 2006a; Holland et al., 2008a; Lukoschek, 2003; R. M. Peters, et al., 2006; Rose, et al., 2000; Wexler, Elton, Taylor, Pleister, & Feldman, 2009). Differing from these previous studies, this study used an age group of 55 and older and predominately African American participant versus the span of adults aged 18 and older and only White participants.

Similar to the results of this study, high quality patient-provider communication in which the patient understands the management instructions as well as the purpose of medications contributes to patient compliance. Additionally, healthcare providers should be empathetic to the individual needs of the patient in their interactions as supported by a recent article (Finset & Gerin, 2008). The patients' experiences with noncompliance demonstrate the complexity of managing hypertension from the patients' perspective and also provide insight into complex responsibilities that their health care provider have in treating and interacting with them in the clinical visit. Patients referred from an outside private physician may initially come to the SHAPP clinic biased with particular perceptions, cultural beliefs, preconceptions about health care providers, use of blood pressure medicines as prescribed, and lifestyle changes for controlling their blood pressure. For example, providers may assume changing diet and physical activity is a simple task; however, when combined with a lack of education, lack of awareness, and a poor environment, patients may be unable to follow their physician's guidelines as stated in a earlier study (Horowitz, et al., 2004). Authors studying noncompliance previously used

survey and blood pressure measurements in older adult populations (Ainsworth, et al., 1991; Bosworth, et al., 2003; Greenberg et al., 2006). This study added to the literature by providing rich descriptive experiences of noncompliance as stated by participants and also focusing on the primary disease outcome of interest, hypertension.

### *Barriers to healthcare*

In this section, barriers to healthcare as identified in analysis of the transcripts are discussed below. The barriers presented are: lack of money and access to healthcare. The importance of these barriers are discussed in hypertension control and connected with previous studies.

### *Lack of Money*

One emergent perceived barrier experienced by the participants in the SHAPP clinic was a lack of money to pay for medicines and to visit a private physician. These financial difficulties had prevented these low-income participants from seeking healthcare in the past and possibly lowered their perceived susceptibility and severity about the risk factors for HTN. Prior coming to the SHAPP clinic, their unawareness of their HTN condition and lack of education about their health were also influencing barriers for these participants. This assertion for this study is supported by previous findings in the qualitative literature (Boutain, 2001; Webb & Gonzalez, 2006a). However, this study contributed to the qualitative literature by focusing on the older adult population of 55 and above, whereas previous qualitative studies focused on interviewing working adults aged 35 and older. Also, this study used semi-structured individual interviews, versus the predominant use of focus groups in the qualitative literature.



*Access to healthcare*

The participants in this study reported many perceived barriers to adequate healthcare experienced in their lives. Having access to a blood pressure clinic which provides affordable care to uninsured, low-income patients was comforting to these individuals. They remarked on how they are struggling to pay for their expensive blood pressure medicines and medical bills in order to control their blood pressure currently and prior to attending the SHAPP clinic. These patients' satisfaction with having access to this SHAPP clinic complements the positive association between access to healthcare and blood pressure control reported by other authors previously (Ahluwalia, et al., 1997; Ayanian, et al., 2003; Hyman & Pavlik, 2001; Shea, et al., 1992). However, this study added a qualitative methodology aspect to the literature, differing from the predominant method of survey methodology of previous studies. Also, this study focuses on the older adult age range versus the entire adult age of 18 and above. This clinic provided participants with a sense of comfort and self-acceptance of themselves as uninsured, low-income populations in an urban city of large income disparities. This clinic provided a welcome haven for them where they could not only be treated to control their blood pressure, but also be encouraged to openly express their personal feelings and concerns as individuals in a caring and supportive environment. A literature review on the testing of HBM on preventive health behaviors found only perceived barriers to be the most powerful construct across study designs and behaviors (Janz & Becker, 1984). However, these studies reviewed by Janz and Becker (1984) are quantitative in design, and this qualitative study adds another dimension to applying the HBM constructs in a clinical population.

### *Falling from exercising*

Falling from exercising was a barrier identified by patients in the results. This was a legitimate concern for older adults who are diabetic. Table 17 displayed the diabetic status of participants in the study. The literature demonstrated the older adults' concern of the fear of falling from exercising (Berkman, 2006). Also, this study added to the literature by using qualitative methods to understand the experiences of older adults and their concerns, such as falling from exercising, rather than using a survey questionnaire to report their concerns.

### *Change in Lifestyle*

Patients talked about their overall change in lifestyle behaviors following their initial diagnosis of hypertension from their healthcare provider. Before they were diagnosed, they reported apathy concerning their health and living an unhealthy lifestyle. The diagnosis served as a cue to action to increase their self-efficacy to make overall changes toward a healthy lifestyle in their homes, workplaces, and family life. The experience with the initial diagnosis of HTN increased the low perceived susceptibility of the participants; then they reported a strong motivation to comply with the instructions of the healthcare provider after realizing the negative health consequences of having uncontrolled hypertension. These findings complement previous studies in which African Americans reported low perceived susceptibility to HTN (Ali, 2002; Carolyn M. Brown & Richard Segal, 1996). A previous study conducted a regression of HBM constructs with the risk of developing HTN among a Black adult population, where only self-efficacy was found to be predictive of HTN risk factors (Newell, 2008). This study's results contributed to the literature by providing a detailed account of the participants' experiences with their perceived barriers, perceived susceptibility, and motivation to comply in terms of their HTN control.

Patients' previous apathy toward their health and well-being and unawareness of their unhealthy lifestyle behaviors were troublesome findings. Although these patients were treated by the SHAPP clinic nurse after their initial HTN diagnosis, many of their chronic conditions could have been prevented. Primary prevention in the form of culturally sensitive community health education to low-income, low-educated, and minority populations is important in order to prevent the continuing spread of chronic diseases such as hypertension, diabetes, high cholesterol, and obesity which are prevalent among this study's participants.

*Changes from noncompliance to compliance*

Similar to changing their overall lifestyle, participants also changed from noncompliance with previous private physicians to compliance after attending the SHAPP clinic. This comes from the strong rapport between the nurse and the participant during the clinic visit and the nurse's ability to empower patients to increase their self-efficacy to control their blood pressure. Notably, one study discusses the need to tailor physician counseling to the individual patient's needs and asserts that a one-size-fits all approach is unsuccessful, in addressing noncompliance in clinical practice (Finset & Gerin, 2008). In previous studies this issue has not been viewed as a change from noncompliance to compliance but mostly as experiences with either noncompliance or compliance with HTN medications (Bane, et al., 2007; Cooper, 2009). This study differed from previous studies in that patients discussed their motivation to comply with the nurse's instructions without hesitation to change their daily routines. Previous quantitative studies have addressed the relationship and importance of self-efficacy in contributing to patient compliance for hypertension control (Finset & Gerin, 2008). One study compared different health beliefs of a non-compliant versus a compliant older adult male population (Andreoli, 1981). Differing from previous studies, this qualitative study suggests that people can and will

make changes with adequate support and appropriate conditions.

In their experiences from noncompliance to compliance with their current blood pressure medications, patients reported their knowledge of the negative consequences of their previously unhealthy lifestyles, their knowledge and education of the risk factors for high blood pressure, and thus their confidence to follow the clinic staff's instructions in controlling their high blood pressure. This study's findings complemented recent studies by emphasizing that non-compliant African American patients discussed low knowledge of high blood pressure and also the consequences of their lifestyle behaviors (Boutain & Spigner, 2008; Boutin-Foster, et al., 2007; Dean, et al., 2007; Y.-S. Lee, 2007; Lukoschek, 2003; Schlomann & Schmitke, 2007). However, this study adds to the literature by discussing the theoretical constructs of perceived severity and perceived susceptibility in the analysis of the participants' experiences with noncompliance.

*Research Question #2: What are the differences in the experiences of Whites and African Americans diagnosed with hypertension?*

The desired comparison of the experiences of Whites and African Americans was precluded because of recruitment and selection challenges. More detail is provided in the section Unexpected Experiences of the Researcher on p. 128. This study contributed to the literature in describing the experiences with recruitment of participants. This study differed from previous studies in which African Americans described experiences with racism and discrimination and their inability to control their HTN (Brondolo, et al., 2008; Krieger & Sidney, 1996).

*Research Question #3: What are the differences in the lived experiences of men and women diagnosed with hypertension?*

The results in Chapter 4 suggest that men expressed a calm, relaxed attitude to life and had little stress in their lives. These men possess some inner peace and try not to allow stress to

impact their mindset and hinder their control of their hypertension. On the other hand, women reported more stressors in their lives, particularly from family members, children, and co-workers. The men reported impersonal factors such as unemployment and road rage, however the women reported stress resulting from interpersonal relationships. This finding is supported by previous qualitative studies in the nursing literature reporting that women experienced more stress in their family and working life as compared to men (Boutain, 2001; Boutain & Spigner, 2008; Higginbottom, 2006b; Liu, Spector, & Shi, 2008; Lukoschek, 2003; Webb & Gonzalez, 2006a). However, this study used semi-structured interviews and a framework of phenomenology versus the focus groups and ethnographic frameworks used in previous studies.

In the psychology literature, studies have reported differences in expressions of stress among men and women. Compared to men, women suffered more stress and demonstrated a more emotion-focused coping style (Liu, et al., 2008; Matud, 2004; McDonough & Walters, 2001; Mead, Andres, Katch, Siegel, & Regenstein, 2010; Tamres, Janicki, & Helgeson, 2002). Men expressed their anger outwardly and discussed everyday activities in their lives, while women internalized their stress. These previous results complemented the differences found in this study as women discussed more stressors in their lives and a more emotion-focused coping style than men. However, this study contributed to the literature by having descriptive accounts of male and female experiences with stress versus reporting survey answers.

Perhaps, women have “anger-in” characteristics and so internalized their stresses and failed to verbalize them until they spoke to a clinic nurse or the interviewer in the study. They felt pressured by themselves to be a good parent and co-worker and felt frustrated in their attempt to lead a balanced life. Their selfless nature to be a perfect parent and co-worker has contributed to their increased stress level now and poor control of their HTN. This study’s

results complemented previously reported positive associations between anger, hostility, and defensiveness with perceived stress (E. Harburg, et al., 1991; Player, et al., 2007; Rutledge & Linden, 2000). Despite these important findings that are discussed, there are limitations in this study which need to be addressed.

### *Study Limitations*

This study used a convenience sample of patients who were being currently seen in the SHAPP clinic. This clinic accepts patients by physician referral or on a walk-in basis if patients meet the screening criteria of hypertension. There are limitations of utilizing a convenience sample in this study. These participants were interviewed following their clinic appointment and may differ than those participants who missed their appointment, who left the clinic, or who were untreated for HTN. The desired comparison of African Americans versus Whites was not achieved since I interviewed only one White patient who scheduled an appointment to be interviewed after the clinic visit with the nurse. I anticipated interviewing an equal number of White males, White females, African American females, and African American males. At the time of data collection, the majority of the patients seen overall in the SHAPP clinic were African American; however, more Whites and more male patients in their 20s, 30s, and 40s were observed whose ages did not qualify them for the study (Appendix A). The clinic's previous 2010 and 2009 reports indicated that there were higher percentages of African Americans than Whites in the age groups of 35-64 and 65 and above (NEGA, 2009). The percentages of Whites and African Americans in the 35 to 64 age group and 65 and above age group were presented (Appendix 1).

The limited access to the clinic for five weeks and limited funding for the gift cards were limitations of this study which are important to acknowledge. In particular, the limited access in

the clinic for five weeks was an agreement reached between the clinic staff, health department manager, and researcher prior to data collection. Prior to data collection, the researcher was allotted money to the fund gift cards for 29 participants in this study attending this particular clinic.

The study conducted was qualitative, and the aspects of its design produce limitations. Since hypertensive patients were sampled from one county health department in one state, the researcher is not able to generalize the findings to the entire cross section of all patients with hypertension living in Georgia and across the United States. The researcher utilized a convenience sample from the SHAPP clinic, many of whom had the time to converse openly in the interview without concern for attending another appointment or meeting. Since the researcher interviewed mostly African Americans participants, the results cannot be applied to other ethnic populations with hypertension like Whites, Hispanics, Asians, Native Americans, Alaska Natives, and those of mixed races.

#### *Study Limitations as interviewer*

In terms of the perspective of the interviewer, there are several limitations to address. The interviewer was younger than the participants by at least 30 years in age and of a different race. The interviewer may have the stamina to complete a 45 minute or hour long interview, however older adults may encounter fatigue at the end of the interview (Rodgers & Herzog, 1992). Also the interviewer's gender may have influenced the men not to discuss their experiences with stress but instead relate that they experienced little or no stress in their daily lives. The men may have become agitated, hostile, or defensive and hesitant to disclose personal information to a female interviewer of younger age (C. A. Miller, 2009). Similarly, the women may have felt more comfortable in the interview setting discussing their experiences with stress to a fellow female.

In terms of race, the interviewer was of a different race than the participants, thus participants may not have felt comfortable disclosing personal details of their lives such as their current relationships with family and peers during the interviews.

#### *Unexpected Experiences of the Researcher*

Immediately after IRB approval, the study was initially advertised for three weeks by posting flyers in the clinic and the clinic staff also announced the study to each prospective patient. Despite these efforts, only three patients agreed to participate by scheduling an appointment with the researcher to meet at the clinic. However when the researcher remained at the clinic all day from opening to closing every day for a month, 26 of the total 29 participants were eventually recruited. The nurse explained the purpose of the study to each prospective participant after their clinic visit, and all of these participants agreed to be interviewed either after their visit or while they were sitting in the waiting room. The researcher also interviewed patients who came to the clinic to get a refill of their blood pressure medicines and not for a clinic visit. The researcher presupposes that being seen in person helped the prospective patient to feel comfortable in agreeing to participate in the study. Additionally, the participants were willing to discuss their experiences in the interview because of their great optimism about the clinic staff and experiences at the SHAPP clinic. Also before participants signed the consent form, 27 of 29 participants asked if the researcher could read aloud the consent form to them instead of them reading it quietly. This may be why the researcher was unable to recruit sufficient participants initially. Participants may not have been able to read and understand the flyer posted in the clinic.

While sitting in the clinic, the researcher observed the patient load during that month period. During the first part and end of the month, only a few patients came to their



appointments or otherwise rescheduled to the next month. Meanwhile, the majority of patients interviewed for this study came to the SHAPP clinic during the second and third weeks that month. Few patients kept their appointments in the first and fourth weeks of the month. The researcher suspects this observation was due to the patients' lack of money at the beginning and end of the month. Following the clinic visit, each patient is required to pay the \$30.00 fee which includes their six month supply of blood pressure medicines. Additionally, some patients may not be compliant enough to follow up at the clinic regularly like every six months but may comply to once a year follow up visit. They may be visiting their family physician, be ill, have other personal or family commitments, have moved to another state, or have started a new job with new health insurance coverage.

Patients continued talking to the interviewer after the completion of interviews. Many patients remarked following the interview about their personal satisfaction with their current health and how their perspective on life has improved since attending this clinic. They expressed often how much they enjoyed talking to someone about their positive experiences in the SHAPP clinic and sharing their story on living with hypertension. On several occasions after completion of interviews, patients and the researcher engaged in conversations about controlling their blood pressure and they felt enlightened with this information. Many of the patients stated they were socially isolated because they lived away from children and grandchildren and were unfamiliar with their neighbors. Their visits to the clinic are one of the few times during the month time when they are able to interact with people for 30 minutes to an hour. The researcher also noticed that most of the participants related after the interview they believed their experiences to be true and their answers to be honest. They remarked that their participation in this interview provided them with emotional support and encouragement to help them through the day.

Also, the researcher noticed the strong candor and great detail provided by participants while conducting the interview and also in the transcriptions. One possible reason was the concurrent transcription and analysis of themes conducted by the researcher immediately following the interviews at the end of the day. The researcher noticed the great passion and excitement the participants displayed when reporting their lived experiences during the interview. Participants noted after completing the interview that they enjoyed answering the questions and felt that they were enlightened by discussing their experiences with another person. Three remarked how they would have completed the interview even if a gift card were not included as an incentive for the study.

### *Lessons Learned*

The researcher learned many lessons as a result of conducting this qualitative study. First, one lesson was learning the process of qualitative research through first-hand experience. With previous limited experience conducting qualitative research, this study provided tremendous experience and lessons in writing interview questions, recruiting participants, and interviewing participants. Specifically, the great attention to detail was learned in transcribing the interviews verbatim and analyzing the interview transcripts. The art of the qualitative interview was learned by carefully listening to each participant's answers and thinking of follow-up questions to ask if necessary. These follow-up questions or rephrasing of questions provided the researcher with the rich detail characteristic of qualitative research. Second, cultural sensitivity was learned during the recruitment of the participants in the SHAPP clinic. Medically underserved, uninsured, low-income, and low-educated populations should be treated with concern and empathy, keeping in mind the barriers which they face as a population such as inability to read a flyer and fully understand a research study in which they are invited to

participate. Initially, the use of flyers posted in the clinic provided few interested participants; however, seeing and conversing with the participants face-to-face in the clinic sparked their interest in participating in this qualitative study.

### *Unexpected Emerging Themes*

Two unexpected emerging themes were accounts of participants' experiences changing from noncompliance to compliance and participants' experiences with previous private physicians. First, participants discussed these themes in-depth without being asked directly questions about them during the interview. Participants talked about their noncompliance prior to attending the SHAPP clinic and their lack of awareness of the impact of their unhealthy behavior on their long-term health. They expressed their thoughts on noncompliance in the past, and their strong desire to motivate themselves to improve their health to control their blood pressure. Second, participants expressed their concern for their previous experiences with private physicians. Participants reported the miscommunication and lack of rapport between the physicians and them during the visit. Each failed to take into account the other's cognitions and perceptions about hypertension treatment and control. Notably, participants recognized the positive communication between themselves and the clinic nurse by reporting how the nurse displayed genuine respect for their feelings as individuals and attention to their concerns as patients learning to control their blood pressure. These findings display the strength of qualitative research in being able to uncover experiences of participants not initially considered; this unexpected knowledge broadens our understanding about hypertension control and about improving patient-provider communication in the clinical setting.

## *Study Implications*

### *Implications for Practice*

These findings support important assertions about the selected sample of older adult patients living with hypertension. These results can inform healthcare providers about the perceptions of HTN among African Americans in this area. Moreover, the stories of patients who incorporated lifestyle changes and have managed to control their blood pressure successfully are described. Particularly, health care providers can benefit from learning about the stories of patients who were previously non-compliant but became compliant while attending the SHAPP clinic. The study as a whole can improve provider -patient communication within this Northeast Georgia Health District's cardiovascular clinic and improve hypertension management and control. In terms of the findings of gender differences in the stress-related experiences, healthcare providers in practice should not treat men and women in the same manner, but be cognizant of their gender-unique attitudes, perceptions, and life experiences and tailor their treatment accordingly to individuals' needs to effectively control and manage their hypertension. This study provides a snapshot of the mindset of a sample of hypertensive patients, specifically African Americans. Understanding this mindset can greatly assist in improving compliance to medical management, which is a significant problem in hypertension management.

### *Implications for research*

This study provides multiple implications for future research. Hypertension research in health promotion should include qualitative methods in addition to quantitative methods in order to contribute to a more holistic approach to hypertension education and control in minority and underserved populations. This study contributes to the literature by providing a qualitative evaluation component to the SHAPP program. Few previous studies on hypertension

interventions or programs have included an evaluation component, either qualitative or quantitative (Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001). In the future, more qualitative evaluations can be conducted to assess if hypertension management programs are achieving their goals and conducting their protocols as originally intended.

#### *Implications for education*

This study has implications for educating future clinicians and public health researchers. In terms of clinical education, this study can assist in training this clinic's future nursing staff and healthcare providers about cultural sensitivity and communication when dealing with older adult populations from different walks of life. In terms of educating researchers, this study can provide insight for doctoral students who are studying health disparities in minority populations or health promotion research and evaluation methods. They can learn about applying qualitative methods to such an important public health problem as hypertension. Also, this study and similar studies can encourage these upcoming researchers to pursue a field which is in strong need of more research and evaluation efforts.

#### *Implications for policy*

This study provides legislators with evidence of the success of the state program in this particular health department at least the patients' perspective. While at the clinic for a month, the researcher noticed that the staff has been reduced by recent state budget cuts. Currently there is one nurse in the Clarke County health department with a district nurse and physician who may provide patient consultations on a case by case basis. Previously a dietician was a staff member and saw patients following the nurse's visit in this clinic; this job was terminated due to state budget cuts. This study can be used to advocate for the increased recruitment and retention of nursing staff and dieticians in clinics in this state's Health District.

### *Future Directions*

The patients shared their high praise for the clinic and remarked on the high quality of care they received; however, several participants suggested some improvements during the interviews. First, a walking program once a week could be created to assist patients in continuing to control their blood pressure and assist in weight loss. For example, participants said that a walking group was previously held at the mall every Friday a few years ago but now has stopped. This type of walking group can also provide strong social support for patients in the SHAPP clinic who are all working to control their blood pressure and make important lifestyle changes. Also, patients in group settings can share healthy habits and tips which have helped them to take their blood pressure medicines, improve their diet, and improve their exercise to help manage their daily stressors to control their blood pressure.

Similarly, a support group can be offered for patients to meet once a month to discuss their positive and negative experiences with managing their blood pressure. After interviews with many patients, they remarked how they very much enjoyed talking about their experiences in the clinic and how they were able or not able to control their blood pressure. Many of the patients interviewed lived alone, and several lives far from any children or family members. Also these patients remarked afterward how much better they felt after talking with someone about their experiences, helping them to understand themselves in a new light. Thus, a setting like an ongoing support group can provide patients a positive environment in which they feel comfortable openly talking to each other and expressing any emotions which they may be suppressing. Furthermore, an ongoing support group can serve as a social venue to relieve social isolation.

In terms of patients who were unsatisfied with the care and hypertension treatment

received, they might be tracked in future studies to understand their experiences living with hypertension. From searching a current computer database at the clinic, these unsatisfied patients may be tracked from searching their name and phone number up to 90 days after their last scheduled clinic visit. Patients who were unsatisfied with their experiences in the clinic may transfer to their private physician, have multiple chronic diseases which the clinic nurse is unable to manage, had a death in the family, believed their HTN is controlled, or moved to another city or state. In future studies, it is important to understand the experiences of these unsatisfied patients in order to improve the quality of the care and rates of compliance at the clinic in the future.

The limitations of this study can be addressed in designing future studies. First, a larger sample of White patients as well as a sample of other ethnic groups can be included in future studies. For this particular clinic, lowering the age bracket to 30 and above to include more African American men and Whites is a possibility to achieve an equal number of each race group in future studies. Challenges in patient recruitment occurred in the data collection site during the study. To address this study's recruitment challenges, data collection at the SHAPP clinic can stop at 15 participants, and the recruitment can occur at another clinic in the state to increase the number of White male and female participants in future studies. Different clinics in the state can be compared in this particular health district and across all health districts to evaluate the state program's effectiveness and compliance rates on a larger scale.

The findings of this study can be used as a foundation for designing qualitative, quantitative, and intervention studies in the future. First, the rigor of the study can be increased through triangulation of method. A qualitative interview can be conducted along with a survey measuring the associations between the patient's cultural beliefs and perceptions about

hypertension and heart disease and stroke prevention, and following their treatment over time. Second, the experiences of the nursing and other clinic staff can be studied in a future qualitative study using a phenomenological framework. In addition to phenomenology, other frameworks of analysis such as grounded theory and narrative analysis can be used. While this study focused on understanding the experiences of hypertension patients, additional qualitative studies focusing on understanding the experiences of the SHAPP nursing staff may be worthwhile. Third, the experiences of this clinic's nurses and other staff can be compared with the patients in a qualitative study similar to a previous SHAPP study of another Georgia health district (Constantine, et al., 2008). This comparison or contrast of their experiences will assist the health department manager and district health director in creating a useful policy and a positive work environment for providing quality care to the patients.

Furthermore, quantitative studies can be designed based upon the results of this qualitative study. A culturally competent survey can be created from these patients' experiences in the SHAPP program to assess the health perceptions of their hypertension awareness, control, and management. Also, a culturally competent survey can be designed to assess and then enhance the patients' willingness to improve their current lifestyles to control their hypertension. Finally, noting the perceived barriers and cues to action from the patients' experiences in the SHAPP program can assist in designing a culturally competent intervention for African American patients to improve their self-efficacy and provide social support in improving their diet, physical activity, and stress management to control their hypertension. Guidance and education on diet and physical activity can be provided by a dietician and exercise trainer in combination with nurses, physicians, and health educators.



*Conclusion*

For this study, the researcher had the opportunity to learn about the experiences of older adults participating in the Stroke Heart Attack and Prevention Program (SHAPP) in the Northeast Georgia Health District's Clarke County Health Department. Many of their stories of successful blood pressure control and management provide inspiration and motivation to those patients who are striving toward blood pressure control or struggling to control their blood pressure. These results contribute to our understanding of hypertension from the patient's perspective and aid our future efforts in designing culturally sensitive chronic disease management programs and educational tools to improve the compliance rates among African Americans. The stories of these participants in this study emphasizes that older adult patients diagnosed with hypertension need to be treated as individuals with care, respect, and compassion, particularly those populations who are low educated, unemployed, and uninsured. Understanding patients' individual unique psyche in real time, particularly for African Americans, who are the most prevalent hypertensives according to recent statistics, should significantly and effectively contribute to compliance, a current problem in hypertension control

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## APPENDIX A

## Active Male SHAPP Clients in NEGA District Fiscal Year 2010 First Quarter

Table A1

Age	Race	Joint Mgmt	HD Mgmt	Controlled BP
<35	Black	0%	2%	62%
<35	White	0%	1%	80%
<35	Other	0%	0%	0%
35-64	Black	3%	11%	54%
35-64	White	0%	17%	54%
35-64	Other	0%	1%	67%
65+	Black	2%	1%	91%
65+	White	1%	1%	83%
65+	Other	0%	0%	67%

Joint Mgmt = managed by physician and health department

HD Mgmt = managed by health department

n = 402 total patients

## APPENDIX A

## Active Female SHAPP Clients in NEGA District Fiscal Year 2010 First Quarter

Table A2

<u>Age</u>	<u>Race</u>	<u>Joint Mgmt</u>	<u>HD Mgmt</u>	<u>Controlled BP</u>
<35	Black	0%	1%	80%
<35	White	0%	1%	71%
<35	Other	0%	0%	0%
35-64	Black	5%	23%	73%
35-64	White	3%	16%	63%
35-64	Other	0%	1%	100%
65+	Black	2%	2%	69%
65+	White	0%	1%	60%
65+	Other	0%	0%	0%

Joint Mgmt = managed by physician and health department

HD Mgmt = managed by health department

n = 402 total patients

## APPENDIX A

## Active SHAPP Clients in NEGA District Fiscal Year 2009 Annual Report

Table A3

Variable	Category	Patients seen	Controlled BP
Age	<35	9%	6%
	35-64	82%	51%
	65+	9%	7%
Race	White	45%	29.5%
	Black	47%	28.8%
	Other	8%	6%
Gender	Male	37.6%	21.6%
	Female	62.4%	42.8%
Enrollment	<3mo	42%	20.5%
	3mo – 1 yr	15.7%	11.4%
	1 yr +	42.4%	32.4%

n = 760 total patients

## APPENDIX A

## Active SHAPP Clients in NEGA District Fiscal Year 2008 Annual Report

Table A4

Variable	Category	Patients seen	Controlled BP
Age	<35	5.6%	3.3%
	35-64	78.5%	59.6%
	65+	15.9%	13%
Race	White	36.6%	28.6%
	Black	55.7%	41.4%
	Other	7.7%	5.8%
Gender	Male	34.4%	24.9%
	Female	65.6%	50.9%
Enrollment	<3mo	16.4%	7.7%
	3mo – 1 yr	12.6%	10.6%
	1 yr +	71%	57.4%

n = 517 total patients

## APPENDIX A

## Active SHAPP Clients in NEGA District Fiscal Year 2007 Annual Report

Table A5

Variable	Category	Patients seen	Controlled BP
Age	<35	7%	4.4%
	35-64	74.7%	54.4%
	65+	18.3%	12.4%
Race	White	32.4%	23.5%
	Black	62.5%	43.6%
	Other	5%	4%
Gender	Male	27.6%	19.7%
	Female	72.4%	51.6%
Enrollment	<3mo	18.1%	10.1%
	3mo – 1 yr	11.4%	8.3%
	1 yr +	70.5%	52.8%

n = 651 total patients



## APPENDIX A

## Active Male SHAPP Clients in Clarke County Fiscal Year 2010 Summer Quarter Report

Table A6

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Variable	Category	Patients seen	Controlled BP
Age	<35	4.9%	7.40%
	35-64	79.3%	70.4%
	65+	15.8%	22.2%
Race	White	17.0%	14.8%
	Black	79.3%	79.6%
	Other	3.7%	5.6%
Gender	Male	45.1%	35.2%
	Female	54.9%	64.8%
Enrollment	<3mo	24.4%	25.9%
	3mo – 1 yr	20.7%	20.4%
	1 yr +	54.9%	53.7%

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Joint Mgmt = managed by physician and health department

HD Mgmt = managed by health department

\*Data specific to time period of data collection

## APPENDIX B

## Verbal script

Hello, my name's Marylen Rimando. I'm from the Department of Health Promotion and Behavior at the University of Georgia. Thank you for wanting to participate in my project. I wanna learn more about blood pressure from your point of view and your experiences at the blood pressure clinic. I would like to interview you here at the clinic. This interview will last no more than 1 hour and 30 minutes. You can decide if this interview will be tape recorded or if I will take handwritten notes. Your name will not be identified with what you say. You'll receive a \$20 Walmart gift card for participating in the interview.

When's the best day and time you can meet me at the blood pressure clinic? I will call you again to remind you about coming to the blood pressure clinic.

Thanks very much for your time and have a nice day. Goodbye.

## APPENDIX C

## Recruitment Flyer

## ATTENTION: PATIENTS NEEDED FOR INTERVIEWS

I would like to learn more about high blood pressure and talk with patients now living high blood pressure. If you are white or African American male or female, 55 years old and above, and have a blood pressure of 140/90 or above, I would like to spend no more than 1 hour and 30 minutes of your time talking with you at the Clarke County blood pressure clinic. You may decide if you want to be tape recorded and your names will not be reported. I will provide you with a \$20.00 Walmart gift card for your participation. If you are interested, please contact Barbara Smith, secretary at the Clarke County blood pressure clinic at 706-542-8600.

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If you have questions about the interview, please contact:

Marylen Rimando, MPH, CHES

University of Georgia

Department of Health Promotion and Behavior

Email: [mrimando@uga.edu](mailto:mrimando@uga.edu), phone: 478-719-7556

This project was reviewed by the Institutional Review Board (project number 2010-10601-1) at the University of Georgia, Athens, GA.

## APPENDIX D

## Interview guide

I'm collecting people's stories of living with high blood pressure. I wanna know what blood pressure's like from your point of view. There's no right or wrong answers to my questions - just tell me what you do, what you think, and how you feel.

Learning about your story can help this clinic improve their blood pressure care for other patients. First I'll ask some questions so I can learn about you. Then I'll ask you about blood pressure. Please take your time and you don't have to answer any question you don't wanna answer. I want you to feel very comfortable telling me about yourself.

When we're finished, if you wanna ask any general questions about blood pressure that I can answer as a public health person, I'll be glad to try to answer them. Do you have any questions before we get started?

## Demographics:

1. How old are you?
2. What race do you consider yourself?
3. How many years have you been to school? Did you finish high school? Did you finish college?
4. How many years have you been getting treatment for your blood pressure?
5. How long have you been coming to the blood pressure clinic?
6. Tell me about yourself and your family.
7. Thank you. Tell me what an average day is like for you this week. Or yesterday?

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**A. Clinic:**

I want to learn about your experiences at this clinic. Tell me about the medical care you get in this clinic.

## Probes:

1. Do you think you are getting the proper medical care in this clinic? If not what is the reason?
2. Do you believe what the nurses are telling you?

3. Are you satisfied with the care you are getting? If yes, tell me why you are satisfied. If not, what is the reason?

4. Tell me how you are being treated by the nurses in the clinic. Can you tell me about a specific time?

5. Do you have a problem getting to the clinic?

6. What improvements or changes in the Clinic would you suggest for better care?

7. What can the Clinic do better to help you manage your blood pressure?

[I will briefly summarize what the participant has answered. ] Is there anything else you would like to say about the clinic?

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#### B. Diagnosis/Treatment Concerns:

Now I want you to think back to when you were first diagnosed with high blood pressure. Tell me how you felt and what happened with your doctor. Tell me what was going on in your life at that time.

Thank you for sharing that. Now, tell me what your life has been like since you were first diagnosed with high blood pressure. Have you made any changes in your life? Tell me about the changes you have made.

Probes:

1. Do you believe that your high blood pressure is a problem that can hurt you ?
2. Do you believe that your high blood pressure should be treated ? Are you serious in following your blood pressure treatment?
3. Are you concerned that you have high blood pressure ? Why ?
4. Do you feel different than other people who do not have high blood pressure?
5. Are you aware of the complications of high blood pressure? If yes, what are the complications? If so, do these complications scare you?

[I will briefly summarize what the participant has answered. ] Is there anything else you would like to say?

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#### C. Control/Management:

Do you control your blood pressure? Tell me how you control your blood pressure.

What helps you control your blood pressure? Who helps you control your blood pressure?

Probes:

1. Are you following your appointments ? If not, what is the reason ?  
If yes, what keeps you coming back to the clinic? Tell me about a specific time.
2. Are you following your diet? If not, why ? What do you eat and drink in a typical day this week? Is there anything that keeps you from following your diet? Tell me about a specific time.
3. Tell me about your exercise routine in a typical day this week. Is there anything that keeps you from exercising?
4. Do you have a weight problem ? If so, are you trying to lose weight ?  
(If you lost weight) Tell me who and what motivated you to lose weight.
5. Do you have diabetes? Do you have problems managing it?

[I will briefly summarize what the participant has answered. ] Is there anything else you would like to say?

Medications: Are you using your medications like you should ? If not, what is the reason?

What do you do to make yourself take your medications?

Do you need help so you can take your medications properly?

Probes:

1. Do you have any problems using your medications ? What problems ?
2. Are you scared of taking your blood pressure medications ? Why ?
3. Do you have a problem with the side effects (bad symptoms) of medications ?
4. Is the cost of medications a problem for you ?

[I will briefly summarize what the participant has answered. ] Is there anything else you would like to say?

Related factors:

1. What and/or who in your everyday life helps you control your blood pressure?
2. Does worry, hassles, or everyday concerns affect how you control your blood pressure?
3. Are there things around you that can make your blood pressure go up?
4. Do you talk to your family and friends about your blood pressure?
5. Are you able to manage your stress? How do you deal with stress? Tell me about a specific time when you managed stress.
6. What do you do to manage stress? What do you do for relaxation? Tell me about a specific time.
7. Are there things you wanna do but cannot do because of your blood pressure? Tell me about a specific time.
8. Why do you think you have high blood pressure? Do you blame somebody for your high blood pressure?

[I will summarize what the participant has said.]

Is there anything else you would like to share with me? Is there anything else I have not asked that you would like to share about your blood pressure? Do you have any questions for me? Thank you for sharing your story with me and appreciate your time today.

## APPENDIX E

## Sample Transcript

Paula (P)

Duration: 57 min

Me: I'm collecting people's stories of living with high blood pressure. I wanna know what blood pressure's like from your point of view. There's no right or wrong answers to my questions - just tell me what you do, what you think, and how you feel.

Learning about your story can help this clinic improve their blood pressure care for other patients. First I'll ask some questions so I can learn about you. Then I'll ask you about blood pressure. Please take your time and you don't have to answer any question you don't wanna answer. I want you to feel very comfortable telling me about yourself.

When we're finished, if you have any questions you wanna ask me about blood pressure as a public health person, I'll be glad to try to answer them. Do you have any questions before we get started?

P: No.

Demographics:

Me: How old are you?

P: 70

Me: What race do you consider yourself?

P: Black

Me: How many years have you been to school?

P: 11 well 12 really

Me: You finished high school?

P: Yeah.

Me: How many years have you been getting treated for your blood pressure?

P: (laughs). It goes way back. But um I actually took it serious – I thought blood pressure was – high blood pressure was something that (pause) you – you take a couple of pills for it and it's gone. I didn't realize it was a lifetime illness. So when I found that out, I took - started taking it seriously and I started taking medications.



Me: And how long ago?

P: Uh and that's been uh (pause) I guess when I was about (long pause) 40 well or a little earlier than that.

Me: How long have you been coming to this clinic?

P: (clears throat) Uh since I been here it's been uh about 20 years.

Me: Tell me about yourself and your family.

P: Um there's not very much to tell (chuckles). I moved down here when I was 50 years old with my husband and my – um well all my - my 4 children were grown with their own families. So the following year (pause) uh – uh my husband and I thought we would um go into uh – uh a getaway so to speak and uh spend the rest of our days together. Um I lost him in uh '08 and um (long pause) I still uh – uh in the meantime uh like I said when I moved - when I moved down here my husband and I um the next year my grandchildren and my oldest son and his family – everybody my - my oldest son's family moved here. And and the kids were put in school and so they have been here since that time.

Me: So you live with them?

P: No.

Me: You live by yourself?

P: Uh huh. So what happened was that they stayed with me until they found an apartment which at the time was a duplex right next to me.

Me: Mmm hmm.

P: (continues) And that's where they wound up. Um uh my – my – my well my granddaughter who was my son's oldest – she was 13 at the time because she was coming out of - of middle school. She only was uh went to middle school for one - that one year – the eighth grade. And so um (clears throat) uh then – then she went out to high school um and she also started but didn't finish um technical school.

Me: Mmm hmm.

P: She had went to technical school.

Me: No go ahead.

P: (continues) That's that my – my – my oldest son's family. Then my daughter uh who was married and um uh had she started her family here in the states but raised and had her second child in uh England because her husband was in the military so uh she didn't get – when she

didn't get back – they put her - put them in Colorado so she - from Colorado she got a job in Atlanta, Georgia (laughs) cause I – she knew that her parents were here so (smiles) um you know and so she landed a job uh a good paying job and they moved her and her family from Colorado to Atlanta and so in the – in the meantime they bought a house after they found out that they liked it – and they - they bought a house. So they're in Georgia. My – my oldest son is still here but he raised his children – his baby is 22 he turned 22, 23 this year.

Me: Okay.

P: Anyway, he um (pause). He uh um (pause) raised- he raised cause when that little fellow he got here he was about three years old (laughs) so it's a - been a long time I been here. And um when we first moved down, my other son came down with us, he stayed down here for four months when we first got here and uh he started working and everything. As soon as the holidays came um – Christmastime – he got homesick from New York because he was born and raised in New York – like all of us were (laughs) – except for the – you know - the littlest – well the littlest two – my - my son's children were born in it was just my daughter – my daughter's children and then my baby boy stayed in New York and he just recently moved him and his family – just recently moved to Virginia. Northern, northern Virginia. So –

Me: So just wanna make sure I'm right. You have an oldest son, a daughter, another son, and a younger son.

P: Yes, I have four. Three boys.

Me: And how many grandchildren?

P: I have 9 grandchildren.

Me: Okay. (pause) Thank you for sharing that.

P: (continues) And I have 2 great-grandchildren. (laughs)

Me: Okay.

P: (continues) That's that 13 year old or 12 year old – she graduated she was 13 um (pause) down turned down here. Now she's married with two beautiful little girls

Me: Okay.

P: (continues) which one is in the car.

Me: Okay. Tell me what an average day is like for you this week.

P: And how?

Me: Average day?

P: An average? Lately it's been humdrum. (exhales). Humdrum. Um I've been a little depressed at times and then you know I pray on it and I feel a little better and I just keep going. That's all we can do you know.

Me: Why would you say you feel depressed?

P: Well actually I've been mild depression since my husband passed. You know I miss – missing him. And so uh but uh I'm dangerous yet (laughs). I don't think I'm gonna get that way. You know long as I have the Lord on my side. I'll be okay.

Me: So what type of things do you do in a typical day?

P: I stay in my night clothes all day. (laughs) I – I – I don't fix my hair. You know I don't have the will to do that um within my house. I don't – I don't go out – I don't receive company but that's not because nobody comes so I don't – if you come yes I treat you.

Me: Okay.

P: I entertain.

Clinic:

Me: Okay, so I want to learn about your experiences in this clinic. Tell me about the care you're getting.

P: Well um I been getting excellent care. Um I was referred here uh from my um my uh how would you say it – my doctor because I voiced to her that I couldn't afford the medications she was prescribing for me. I couldn't keep up with my medicine and it was affecting my health. This - the asthma – I kept having asthma attacks and had to go to the emergency room and things like that and simply because I wasn't taking my medicines she kept prescribing for me cause I didn't have it you know. I used it when I had it when it was gone it was a struggle to get you know money to – to get more medicines so cause it took me a while to get a job down here. And –

Me: What type of job was that?

P: Oh don't ask. I used to work for the school district. I was a custodian. But I started out - the first job I got down here coming fresh from an office job with a big company in New York (laughs). Okay I wound up cleaning rooms in – in a hotel. I done forgot what they call it now. Got a new name, they fixed it up now, a different name. That same property. And uh I used to make beds and clean toilets and showers and you know. Whatever the custodian – how do you a housekeeper – I was housekeeping in – in - in the hotel. And uh from there I moved to another hotel with a little more class to it. And time I got there I got hired and they got graduated – um uh promoted because they were in that category the way they did their customers and so forth and the way they did things was a little more class. The way I came from (laughs). So – so

anyway I stayed there uh about – what – three or four – was it three or four years and um from there I got a job as a custodian at the school district. And I retired there – I worked there 10 years and I retired. Just that the brink of uh when was it was 64 and I turned 65 that summer.

Me: Okay.

P: I – I stopped working June – 64. No. Yeah. In July I was 65 – I turned 65 years old so

Me: So you retired when you were 65? Is that right?

P: Yeah, I guess you would say that. Yeah.

Me: Okay. Do you think you're getting the right care at this clinic?

P: Well I have to get used to the new things – what they doing now. They cut out a lot of stuff that they were doing. And – and – I - I basically um treating them a little more like my major doctor than – than my doctor

Me: Mmm hmm

P: because I got all the tests and they kept up with my health.

Me: Mmm hmm.

P: Mammogram. I haven't had a mammogram in quite a while which I think we discussed it and I was supposed to talk to my doctor about that because they are not allowed to do – go that far anymore. So something, something she was explaining to me.

Me: So they don't give mammograms anymore.

P: I don't think, I don't think they uh – they doing the mammograms anymore. They won't do the – uh how you call it? the – the physicals –

Me: Okay.

P: You know give you the complete physical they were giving – and um.

Me: When did they stop?

P: They were doing so much and they were getting so little. Money wise. But that's the way it was and so now I guess so now they figured they making it better for them that they don't have to do all that work. But they've cut out all the good points (laughs) basically of coming. Had I – I you know just about everybody here cause I been coming here that long but for someone new coming in –

Me: Okay.

P: It doesn't seem to offer as much as it used to.

Me: Do you believe what the nurses are telling you?

P: Yes I do. Yes I do. They um – we - I talk to them like they're my friends.

Me: Okay

P: You know and they let me know and if it's something they don't know they call the doctor. And – and check with him before they tell me anything that they're not sure.

Me: Mmm hmm.

P: And I appreciate that.

Me: Okay.

P: And when they feel like it's something they can't handle, they suggest I go to my doctor to see what she says.

Me: Okay

P: So –

Me: So you are satisfied with the care you're getting here?

P: Oh yes. Yes I was. I still am. I really you know. As I said for what they can give, they can only give what they can give. They have bosses too (laughs).

Me: So how do you feel you are being treated by the nurses?

P: Um like a friend. I would say like a friend. They um so um pretty much um as I said the ones that are left here there's quite a few that left and well she's the one who used to work here one of the nurses, those head nurses and uh so now she works for the doctor where I have my colonoscopy. She works at his place she's a nurse there.

Me: So you feel they treat you well here as a patient? You feel they treat that the nurse treats you well here?

P: Oh yes. By all means. It's nothing – I have nothing bad to say about the – the place – no more than I can – now I notice the change when they told me you know I was kinda surprised but hey you have to do what you have to do.

Me: Do you have any problems getting to this clinic?

P: No.

Me: Do you have any improvements or changes in the clinic that you would suggest to get better care?

P: (Pause) Not really. No more than you know bring back some of the –benefits that they had but that's uh – I think they cut some of those benefits out because they cut down their staff. They didn't - they were being overworked. But they held their own until somebody came in with this - this new idea I guess. (chuckles)

Me: Is there anything that the clinic can do better to help you manage your blood pressure?

P: No because ever since I been here – since uh my doctor referred me here because at that time they were giving blood pressure medicine free.

Me: Okay.

P: Okay. And so she figured that would help me and so she referred to – to come and that's how I got involved with this clinic cause I was going to my doctor. I – I uh was here (pause) two months you know. I was here. I got here August and November I spent two days at the hospital. That's when I found out that I was diagnosed with asthma which I never had in my life.

Me: Okay.

P: I had a lot of allergies.

Me: Okay.

P: And – and like that but I never – I was never diagnosed with asthma in New York. And so they wanted to know how long I was gonna stay and told them I just moved like – like a barrel down here you know to – to make a life down here

Me: Mmm hmm.

P: So I wasn't intending on – on moving to the rest of my life taking my medication for it.

Me: Is there anything else you wanna say about this clinic to me?

P: Um no more than it – it would be a shame if it was to be uh – uh – uh how would you say, dispersed.

Me: Okay.

P: Stopped I mean they done enough by taking away a lot of the uh – activity that was going on here but um I can understand the – the cutting things because of the economy.

Me: Mmm hmm. (pause) So now I want you to think back to when you were first diagnosed with high blood pressure. Can you tell me about that time?

P: (chuckles). Uhhh (pause) I was working for this insurance company in New York City. And got up one morning – I used to take the express bus to work. I got up this morning and um I was so dizzy, lightheaded, very lightheaded, you know but at - at the same token at that time I used to drink.

Me: Okay.

P: Okay. So I had thought I was having a hangover. So I went to work thinking um Pepto Bismol or I mean not Pepto Bismol uh Alkaseltzer and things like that. So all day long I – I usually like by 12 o'clock I'm okay.

Me: Mmm hmm.

P: And uh I just – I didn't get any better. I was getting worse. And so we happened to have a physician that my company dealt with on the floor in the building I worked in. And so they took me there because I was – I was – I was out of it. I was gone. I think I was getting ready to pass out or whatever but anyway when I got upstairs my blood pressure took it about to clock me in at 180/120 and he refused to let me go anywhere until he found out if he could get it to come down himself or long enough for me to get you know at least get home or other than that he was gonna put me in the hospital in - in Manhattan and I lived in Brooklyn so I was like "Oh no!" you know so anyway that's when I found out that I really had to clock myself because I almost died.

Me: Okay.

P: (chuckles) That'll wake you up. (laughs)

Me: And how did you feel at that time?

P: I was just out of it. Just – just out of it. And – and um another thing I was – uh throwing up. I kept throwing up. I couldn't hold anything in my stomach and I was just so dizzy. I had to lay a certain way to – to not feel the spinning.

Me: Okay. Why do you think you were diagnosed with high blood pressure at that time?

P: Oh I know why.

Me: Okay.

P: My - my eating habits were out - outrageous at that time. As I said I used to eat a lot of salt. Hot sauce, peppers, everything that a normal person (laughs) would pass up sometimes, but me I had to have it every meal. I used to put it - hot sauce on my eggs. You know, stuff like that. And uh the saltier something was, the better I liked it. And the salt did it to me.

Me: Okay.

P: Not like some people say pork.

Me: Mmm hmm.

P: In my case, it wasn't the meat, the pork, it was salt. By itself. Once I cut down on the salt, changed my diet and – and started taking my medication everyday, I had no more problems. Only time is if I'm sick with something else and my pressure'll go up a little bit. Or if I'm not (clears throat) taking the medicines. All I have to do is raise my voice.

Me: Mmm hmm.

P: That's how serious my blood pressure is. When I realize all of this – yeah – it was time for some changes. Biggest change I did uh – I continued to drink what I called myself making it the doctor even told me that I could drink a mixed drink occasionally.

Me: Mmm hmm.

P: My occasional drink was every day.

Me: Oh.

P: I drank every day after work. Okay. So um whether I went out or I went home I had myself a couple of cocktails and I ate my dinner and I watched my tv shows (laughs) you know but everything was surrounded by alcohol. And then what happened – um when I moved – when I moved down here and had to change my medication. I was doing fine with the medication they had me on. Oh uh in New York for years and um I drank on it and it didn't bother me. I was good. It didn't bother my blood pressure. When I came down here and got sick with the asthma, they changed my medication for the blood pressure. Ha (smiles) I don't know if that makes sense but they did. And um I think the changing of the medication and God himself said I've had it with this one. Because he turned me against alcohol.

Me: Okay.

P: I couldn't – every – every time I attempted to drink I would nauseous – so nauseous which I hated to do.

Me: Mmm hmm.

P: And you know it just was a bad scene oh and the headache. I forgot uh - my – my grand headaches.

Me: Mmm hmm.

P: After two drinks and I was a drinker. And I stopped after two drinks. Two drinks was enough for me. So finally somebody said (laughs) you know God said that's it.

Me: Okay.



P: That's it. And so I said God's trying to tell me something I better, better well listen or I won't be around to talk about it much longer. You know that's what happened and I won't touch another drop. And it didn't bother me. And my husband was still drinking, my friends you know. It didn't um it didn't bother me at all. But I did hang on to the cigarettes a little longer. I smoked, but I come to find out I didn't need as many cigarettes because I use to chase my cigarette – chase my liquor with my cigarette.

Me: Mmm hmm.

P: If I didn't drink liquor I didn't need my cigarette that much. But I was still smoking. And my doctor wanted to me to stop for the good of the asthma. She said it wasn't good to have asthma and smoke. I didn't need it. So I kept playing around with that – playing around with until – until and stopping – stopping it what happened. And finally I quit that. So it's been years that I've done either. Praise the Lord. (laughs)

Me: Thank you for sharing that. Have you made any changes in your diet since you were diagnosed with high blood pressure?

P: Oh yes. I have lowered my salt intake definitely. And um sugar. Yeah I have moods of - of sweet things it's so I guess I'm a drinker they say when you, you drink sugar you know you have the, the taste buds for uh sweets. So maybe that's what it was. I just never was a sweet bud. And when I do get a taste for it I get it, that's the end of it. I don't continue to eat it. You know. So um my uh my diet – my attitude (laughs) my attitude definitely changed because as I said I didn't take it serious that it was anything that bad. You know just something that the doctors could get their money. You know. And I found out that it wasn't a play thing. That it could just well take you away from here as anything. So I didn't want that cause I still had to raise my children.

Me: Mmm hmm. So you believe that blood pressure is a problem that can hurt you?

P: Oh, I'm sincere it will kill you. Blood pressure will kill you if you do not take care of it. It will definitely kill you.

Me: So you believe your blood pressure should be treated?

P: Yes cause as long – as long as I have the medication, and I don't ever know how long I could last without the medication because when I do go without it I um feel a little rise when I get angry.

Me: Okay.

P: I – I can't have any emotions without any medication. So – it's not a like it's uh a crutch you know like some people take medicine just for a crutch what – just for the sake to say well I'm well now nothin's gonna happen to me. That's that's not the way this is. Because if I stop taking

my medicine, all I have to do is to get angry. Good and angry and my blood pressure shoots up to the sky. (laughs) You know.

Me: What type of things uh make you angry so that your blood pressure goes up?

P: (in a high pitch) Ah (chuckles). It's not much really. It's not much. But um (pause) to be honest with me it's usually paying bills and when my children do stupid things uh sometimes I get angry with myself some – because of something that I've done that you know I'll get angry with myself but that doesn't carry on like it does like if I'm actually uh like you and I are fussing back and forth and my blood pressure goes up one of these things but if I – if I stay quiet you know go back, go back at home, home. Usually what I try to do when I do get angry and upset like that, I try to – I go and sleep. I lie down just to be quiet and when I wake up I'm better.

Me: And so you say you go to sleep and lie down. Does this happen often? Is this really how you manage your stress?

P: No, no. I – I do a lot of crying too sometimes. I did the crying since my husband's been gone cause I don't have anybody to really talk to. My, my son, he's a grown man and he – he stays with me but it's not the same.

Me: Okay. So you would say that you're serious in following your blood pressure treatments?

P: Oh yeah. I better, I'm not ready. I say I miss my husband but I'm not ready to join him yet.

Me: So you are concerned that you have high blood pressure?

P: Now it, it was um a trait my mom had it.

Me: Okay.

P: And um I believed my grandparents (long pause) but they – my – my mom had it when she wasn't taking any medicine for it and she didn't go to the doctor. And – and – and uh the older she got she, she developed um sugar and uh eventually she uh developed cancer and nobody knew she had it, she didn't even know it. The doctor never told her until it was – when it was discovered and they had to say something to her uh it was too far gone, there wasn't anything they could do. So -

Me: Do you feel any different than other people who do not have high blood pressure?

P: No. Not really. Only, only when you know these, these little things. I know say the signs if, if, if I wake up with a headache I'm concerned. And I – I have my own monitor and I take, check it and – and it's anything but normal, then I go to the doctor.

Me: Are you aware of the complications of high blood pressure?

P: Such as? Um

Me: Can you tell me what they are?

P: Complications. Uh you could have a stroke.

Me: Okay.

P: (laughs) Definitely if it gets too high and it also uh if –if uh you could have a uh – how you do – um I believe it's um clots. Um they can travel and – and once they reach your – what is it – your heart or brain that's – that's it. That's another bye bye birdie. Um it's just it's a lot of stuff that uh I have uh and especially now that I'm gettin older. I think about my – my situations like my mother went through and how my husband, my husband was sick for a little bit before he passed. And um he was one of these people, "I'm not sick." He would get me to the doctor in a hurry.

Me: Mmm hmm.

P: If I sneezed – you know – he had me ready to go to the doctor but um him he – he never got sick. I'm okay. I'm not sick. I'll be all right. When he was really down, he'd make himself a cup of tea (laughs). That was it. You know. And uh my, my oldest son is just like him (laughs). He's just like him. I – I don't know why they hate – well I, I guess I do know now why cause I used to do the same thing. I used to avoid going to the doctor. Until the last minute in the way I just had to. I wasn't a person stayed in the doctor's office all the time.

Me: So would you say that the complications of high blood pressure scare you?

P: Yes. Yes. Yes they do. Something else that scares me and I'm, I'm thinking sitting here talking with you is that my lifestyle that I've got going now with the couch potato business.

Me: Mmm hmm.

P: I need to get out and exercise because um my body is talking to me. I'm stiff, um I won't have the strength in my hands and it wasn't like I use to. Not even halfway really. Like to open the jar. You know. I just don't have that – that grip anymore.

Me: What do you think keeps you from exercising as you should?

P: Lazy.

Me: Okay.

P: (laughs) That's number one. Lazy. And – and then like I said when you're feeling "Yeah what the yeck" that's why I said it's a depressed mood that I'm in. Well you know, what's the sense in putting on your clothes. "When you're going?" (chuckles) You know, I don't drive so anywhere I go somebody has to take me. So I just stay in my little – my little cubbyhole my house. Not my house – well it is my house – it is my apartment. I have a – I have an apartment that's – that's in

my (pause) in my um subdivision it's, it's a handicapped apartment on the first floor. I have a little porch so it's like a having little house and but I do have people over me across the hall. Uh it's like somebody across the hall from me, two people across the hall. It's four apartments on each level and the levels go up to two, three – third or fourth floor. And some of the buildings, the way they got it over there the apartments, anyway so I've stayed in and I was getting out walking to the mailbox and then my son started going picking the mail up and so I stopped. So I don't even get up to do that. You know all the walking, all the walking I get is around the apartment from room to room. And then I sit on the couch but my – my legs – my legs at night sometimes start to tingle and then makes me think my circulation's getting low. I gotta get up and start doing something. The only time I get out is um I try to get to church on Sundays.

Me: Okay.

P: And um if I stand too long even when I get up – go to – to the grocery store. Uh if I stand too long, my back hurts so other than that (laughs). I guess I'm doing pretty good for a seventy year old woman. God willing I'd be 71 my birthday in July.

Me: So would you say that you control your blood pressure?

P: I would think yes, that it is very much controlled. Thank – thank goodness for the - this clinic with the pills.

Me: And how do you control your blood pressure?

P: By taking my medicines, on time every day. And try my darndest to get when – when my pills are getting low get here to get a refill before – before they run out. Yeah this past time, I was supposed to be here back here for an appointment in March and um I didn't get back here until now, a month's difference. So in the meantime, that little extra, extra pills I had run out. I didn't have any pressure pills. And but I was, they told me when I run out of pills like that, don't - if I have water pills take that. And that, that's what I do too. So it – it wasn't too bad. Not too bad. But if I had not been taking anything, can you imagine a month? In a months time would go without medications? I would probably been in trouble a little bit.

Me: Is there anything or any person that helps you control your blood pressure?

P: Me and God. Because I do know the importance of it all. And I am not ready to leave here as I said before. I'm not ready to leave yet (pause). God willing for that. (clears throat). When I know something's that gonna hurt me, a lot of salt, and a lot of smoking and stuff like that is not good for me so I don't do it.

Me: Are you following your appointments here as you should?

P: Mmm hmm. Pretty much. Like I said, this time um it was financial more than anything else. I didn't have the money because of my son and has been without work and I've been trying to help

him and I'm on a fixed income now and it's kinda, it's kinda rough but we'll make it. Just like I tell him. We'll make it.

Me: Is there a reason that keeps you coming back to this clinic?

P: Mmm hmm. Cause I feel at home here. I like the people here. (pause) It's sometimes believe it or not it's like talking to you now, um sometimes I go months and I don't even have a – a one-on-one conversation or a group conversation with anybody else but my son. And – and I can't do too much with him either you know so I'll sit there and I'm, I'm, I'm in my own, my own world I'll read my Bible, I'll look at tv, my hands I used to crochet and um I think I overdid that cause I haven't done it in a while because my hands hurt. It's like arthritis. So I haven't uh been doing that – I – I knit a little bit too. And um I used to fish. I used to love fishing, but saltwater fishing we used to do in New York. I don't like this freshwater fishing too much. And my husband didn't either. We would go on a good fish every weekend. We want the fishing boat would take us out but uh (pause) down here and not thinking you know never been living in the South we – we – not that was the last part – I said fishing, fish, fish, you know. I didn't know there was a difference freshwater and uh saltwater. So they brough all our equipment on poles and stuff to no rail. It was you know I mean unless we went with them somewhere with saltwater to fish we could have our own poles.

Me: Thank you for sharing that. Can you tell me what you eat and drink in a typical day?

P: (pause). Ahhh. I have one cup of coffee which I didn't have this morning cause I didn't know if I was gonna have lab work or not. Um sometimes I have a bagel with cream cheese sometimes I have toast or margarine. I don't care for jelly on my toast. (chuckles) Like some people do you know. I don't. Uh by the time I have that, that usually lasts me until about one, probably one o'clock. Maybe sometimes if I have a piece of fruit. I like uh temple oranges without the seeds. I like to eat those. And I'll mess around with that uh I try to drink water. I try to drink more water than uh you know accustomed to doing. Uh because I – I can notice my urine it gets dark. I don't drink a lot of sodas. I just don't drink. I dehydrate I think. I dehydrate more than anything else. (pause) But um the, the one meal I do have is – is uh supper – about supper time, uh 5:30, 6 o'clock and I'll have um a plate of food. My son and I both need to eat this way. Him more than me. But uh (laughs) but uh he uh keeps like tuna.

Me: Mmm hmmm.

P: Canned tuna in water. Uh he keeps that in the house and salad. If I – if I get hungry, I'll eat sometimes earlier than, than one o'clock and I just have coffee. I'll go make a salad if I have a cucumber, tomato, you know and lettuce. I'll whip me up a little salad and sometimes he buys the bag that's already mixed, I like Italian dressing. Anyway um at, at supper time it's it's usually um meatballs, spaghetti, um chicken, uh fish, that's uh (pause) actually (pause) um what did we have? Um that big bag, box of barbeque spareribs or sometimes I'll, I'll get that and um I only need to open one, one slab at a time for the two of us cause I'll have a few of those and

that's, that's a meal. And um baked – baked – baked chicken although my, my son prefers fried and also same thing with fish. I bake my fish and he'll eat it but he, he likes fried fish so but he – he's been coming around to my side.

Me: So you are telling me that you think you need to lose weight?

P: (emphatically) I know I need to lose weight.

Me: You know you need to lose weight.

P: I – because um what's the nurse told me I gained 7 pounds. I've gained 7 pounds but I guess that's all to do with I'm not exercising, I'm just laying around doing nothing so –

Me: Is there anything that keeps you from following your diet as you should?

P: As long as I have you know money uh and with my son being out of work and everything he got – he was able to get food stamps so that's his contribution cause I have to pay the rest of the bills. I have uh something that I didn't have to pay before. A car note. Cause our car - it looked like soon as everything happened when he lost his job – the, the car broke down – my other car broke down. Instead of fixing it, you might as well get a new one everyone was telling me so that's what we went and got another used car not a brand new one but um it's 240 dollars a month that's coming out of my check that I have to pay and then I have to keep insurance on it and we have an insurance that I pay 77 dollars and to have full coverage until we pay for the car. Which we get a nice down payment so it uh it's working now. It's working right now. He – he doesn't uh work and I have to pay those bills – that's that's part of my – blood pressure I guess too. And the way I feel so down all the time because it's – you know it's hard – really hard. We weren't promised this would be easy so I just take a bit of the sweet.

Me: Do you have diabetes?

P: No. Thank God. No I do not. I don't need to have anything else than what I got. (laughs) That's the truth.

Me: Are you using your medications as you should?

P: Yes.

Me: What do you do to make yourself take your medications everyday?

P: This is my bag (pulls it out). This is my bag I have. This is what I got today. I had to come (opens bag). This helps my cholesterol which is I've been doing very well. I take two of these at, at nighttime. This is the pressure pill and this is the water pill. That's it. I have it – I keep it in here. It's on my nightstand right by my bed and so when I get up in the morning. First thing I do is take my pressure pill and my water pill. I don't take any more medications till nighttime when I go to bed. I take my two so that's my part. (laughs) That's my part to do it at all.

Me: Is there a time you forget to take them?

P: No. No more. Maybe when I first started taking all those medications. But when you change, once they told me about the asthma and everything about that and this is something else and I have to talk to my doctor about it. This is the inhaler. I discontinued more than she had prescribed for me cause I told her it was too much money. Cause last time they charged me 60 dollars for it. It's a pump! (laughs) Where do I – where do I get this money from? So this one I use as necessary. I don't have to use this everyday, as necessary. It lasts me longer but even this they raised – I was paying 18 dollars for it next time it was 36 dollars now, now it's 39 dollars. This – this last pump, well not this one. It's the one I refilled. It costs me um it's the same thing. It costs me um 39 dollars in – in change. And I'm saying everytime I come for a refill. This is gonna be going up. She gotta give me something else. I can't afford this. Cause this at first was a generic. It was less – it was less plus it's more money.

Me: Do you need any help from anyone to help you take your medications?

P: Shakes head.

Me: Do you have any problems with your medications?

P: No.

Me: Are you scared of taking your medications?

P: Not at all.

Me: Do you have any problems with the side effects?

P: No side effects. If I did, I would mention it to the doctor or you know come back to the clinic and tell them. They tell me I should call if anything like that happens.

Me: Okay. Is there someone in your everyday who helps you control your blood pressure?

P: No. (pauses). No it's only me and the man upstairs.

Me: Do worries, hassles, or everyday concerns affect how you control your blood pressure?

P: Worries.

Me: You know worries.

P: (Exhales) No, not really. I know what's gonna happen if I don't take my medicine. Even if I have to call my children to help me get my medicine which my children tell me "Do not go without!" – they chewed me out recently when I get this business of the month. I get chewed by my daughter and my son and the son, he's the one that squealed that talked to the others – they're

older than him. He told them what I had been doing and they know the situation. Boy, they chewed me out! (laughs)

Me: Is there anything else you wanna share with me?

P: (laughs) Should I? Should I? No, no this is the only time – everyone once in while, something happens that I won't get my medicines and for whatever reason I'll put it on hold and it goes beyond the – the time and somebody will find out that I'm not taking my medicines because I don't have any and say "Mom why didn't you tell me! Why didn't you say? I don't want you to do that no more! That's dangerous! Blah blah blah.." ahhh I gotta listen to all that but you know. They're telling me the truth. But you know. Sometimes you have to do what you think is sometimes best too. Um it's – it's something more important.

P: We're having a big party in here!

Me: Um I just - I just really wanna thank you for sharing your story with me. I really enjoyed talking with you. I appreciate all – all this fun stories. I hope you have a wonderful day.

P: I'm very much pleased to have met you. Nice talking to you.

P: It – it did me all the good in the world I can say oh I did have company. Even if I had to go to the clinic to get it. (laughs)



## APPENDIX F

## Consent form

I agree to participate in a research study titled “Understanding the Lived Experiences of Older Adults Diagnosed with Hypertension”, which is being conducted by Marylen Rimando, MPH, CHES, Department of Health Promotion and Behavior, University of Georgia, (478) 719-7556. This study is under the direction of Dr. Jessica Muilenburg, Department of Health Promotion and Behavior, University of Georgia, (706) 542-4365. My participation is voluntary. I can refuse to participate or stop participating at any time without giving any reason and without penalty or loss of benefits to which I am otherwise entitled. I can ask to have information that can be identified as mine returned to me, removed from the research records, or destroyed if the information can be identified as mine.

The purpose of this research is to understand the lived experiences of older adults with high blood pressure. It is important to increase the knowledge of high blood pressure and create strategies that can help lower and manage high blood pressure among older adults in the future. This information can lead to improved hypertension management and treatment for the older adult population and the health care providers who treat them. Approximately 24 participants will participate in this study.

I may benefit from learning about the stressors which contribute to my high blood pressure and may learn how I will be able to manage my blood pressure in the future.

If I volunteer to take part in this study, I will be asked to do the following things:

Take part in an in-depth individual interview. In this interview I will be asked to talk about my experiences living with high blood pressure and how I have been able to manage my blood pressure. This interview will take no longer than 1 hour and 30 minutes and I will decide if it will be audio-taped or if I prefer for the researcher to take handwritten notes of what I say. I may be contacted to review my interview transcript or answers as a follow-up procedure about 2-3 months after the interview. I may be asked verify or clarify my answers for about 5 to 10 minutes.

I may feel nervous or uncomfortable discussing my experiences living with high blood pressure and interacting with family members or health care providers. The researcher will allow me time to answer each question and I can refuse to answer a question if I feel uncomfortable or nervous. No risks are expected with my participation in this study.

Any information that is obtained and connected with this study and that can be identified with me will remain confidential with the researcher. If I decide to have my interview audio-taped and the researcher will be the only person to have access to the taped interview, however I have the option to review and/or edit any of the taped information. There will be no known identifiers used on the transcription of the interview. The taped interviews will be destroyed after the interviews and all of the information has been transcribed. All raw data, including transcripts will be retained by the principal investigator for three years after completing this research project. The researcher will answer any further questions about the research, now or during the course of the project, and can be reached by telephone at (478) 719-7556.

I will receive a \$20 Walmart gift card for my participation in this interview. I will be asked to sign and date a form confirming that I have received the \$20 Walmart gift card. This information will be given to the Business Office at the University of Georgia Department of Health Promotion and Behavior for audit purposes. The researcher(s) connected with this project will keep my information confidential by storing it in a secured location.

My signature below indicates that the researcher has answered all of my questions to my satisfaction and that I consent or volunteer for this study. I have been given a copy of this form.

---

Name of Researcher  
 Telephone: (478) 719-7556  
 Email: [mrimando@uga.edu](mailto:mrimando@uga.edu)

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Signature

---

Date

---

Name of Participant

---

Signature

---

Date

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu.

## APPENDIX G

## Incentive payment form

I have agreed to be a participant in a University of Georgia project # 2010-10601-1 conducted by Marylen Rimando under the direction of Dr. Jessica Muilenburg. I understand that participating in this interview entitles me to receive a \$20 Walmart gift card as described in the consent form.

To verify that I have received this \$20 Walmart gift card, the Business Office at the University of Georgia Department of Health Promotion and Behavior requires that I sign and date and print my name for audit purposes.

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*Signature of Participant*

*Date*

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*Printed Name of Participant*