Living with Hypertension: Experiences of Black Men Related to Their Perceptions of the Clinical Encounter at Diagnosis

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Dedication

To my loving husband, Rodney, who makes everyday brighter. You are my strength and support. You encourage me to be more than I ever dreamed and because of you, this goal is now a reality.

To my Mom, Maxine McCartney, who knows firsthand the devastation and loss hypertension can bring to a family. Thank you for your love and support, and for what you mean to our family.

In memory of my Father, Glynn McCartney, who left us way too early due to a hypertension related illness. Your life was cut short, but your strength remains with your family.

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I would like to express my sincere appreciation to Dr. Sandra Thomas and the University of Tennessee's College of Nursing faculty and staff for the professional and welcoming environment that extended my learning to a level I had never before experienced. At the beginning of this program, Dr. Thomas told me and other students entering the program to remember that, when life happens, we may need to adjust the course, but if we choose to work hard with focus and determination the goal would be accomplished. This comment let me know that I was exactly where I needed to be.

Finally, but not least, I acknowledge my faith and trust in God to provide me with the strength and wisdom to endure. He did not fail me.

Abstract

Introduction: In the U.S., hypertension (HTN) is the most common primary diagnosis and HTN related illnesses are the number one cause of death. Being a member of the Black population increases the risk for developing HTN. Black males are reported to develop HTN earlier in life and have a high incidence of undiagnosed, untreated, and uncontrolled HTN. Sociocultural and gender barriers influence this population's perceptions of medical experiences, which affects their participation in health-promoting behaviors such as eating a healthy diet, engaging in regular physical activity, avoiding tobacco, limiting alcohol consumption, and decreasing stress.

Purpose: The purpose of this study was to increase nursing and interdisciplinary knowledge about the clinical encounter at the time of diagnosis from the perspective of Black males, aged 18 to 44, including how their life experiences at and after diagnosis were influenced by that encounter. The overall aim was to generate knowledge useful in the development of practice interventions that improve outcomes, reduce costs, and decrease health disparities for Black men with HTN.

Method: An interpretive description qualitative method, as developed by Thorne, was used for this study. Semi-structured questions guided data collection during private one-on-one interviews with participants. Data analysis was an inductive process informed by constant comparative analysis.

Findings: The consensus of the 17 participants was that, while healthcare providers were polite and professional the information provided at diagnosis did not meet their needs for managing HTN. Themes identified were denial, fear, and frustration. Most participants believed HTN happens to older people, an assumption that promoted denial of their condition. Knowing loved ones who suffered from HTN related illnesses led to fear when acknowledging their own diagnosis. Participants reported engaging in some health promoting behaviors. However, limited education, support, and motivation often resulted in unmanaged blood pressure and feelings of frustration.

Conclusion: While it is evident that educational opportunities exist during and after diagnosis, the men received little more than confirmation of their condition. As the focus on disease prevention increases, the provision of adequate resources to help Black men manage HTN should become a research priority.

Keywords: hypertension, Black men, diagnosis, clinical encounter, healthcare provider interactions

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List of Abbreviations

AHA	American Heart Association
BMI	Body mass index
CDC	Centers for Disease Control
CHW	Community health workers
CVD	Cardiovascular disease
DNA	Deoxyribonucleic acid
HBP	High blood pressure
HCP	Health care professional
HTN	Hypertension
PI	Primary investigator
JNC	Joint National Committee
NCHPDP	National Center for Health Promotion and Disease Prevention
NHANES	National Health and Nutrition Examination Survey
NIH	National Institutes of Health
REACH	Racial and Ethnic Approaches to Community
RHA	Resident health advocate
SNP	Single-nucleotide polymorphisms
USDHHS	U.S. Department of Health and Human Services
VA	Veterans Administration
VAMC	Veterans Administration Medical Center

Chapter One: Introduction

Introduction

The Centers for Disease Control and Prevention (CDC, 2010a) report hypertension as the most common primary diagnosis in the United States, with 31.3% of U.S. adults having the condition (CDC, 2014). In addition, one in every four adults has prehypertension, which puts them at risk for developing hypertension. Hypertension is a major risk factor in the development of heart disease and stroke. In the U.S., heart disease is the leading cause of death and stroke is the third leading cause. In 2010, an estimated $76.6 billion in healthcare services, medications, and missed work was attributed to HTN-related illness (CDC, 2014). The American Heart Association estimated the direct and indirect costs of heart disease and stroke to be $475 billion in 2009 (CDC, 2010b). In addition to the health burdens on society, the human costs alone justify exploring how people respond to the clinical experience of being diagnosed with hypertension.

This study includes an exploration of the perceptions members of a minority group, specifically Black males; have about their clinical experience at the time of hypertension diagnosis. For this study, the term *Black males* describes the target population and members of a population with shared experiences. Using the socially constructed identifier "Black" rather than "African American" provided a more inclusive study population that encompasses members who identify themselves as Black but not African American (Barksdale, Farrug, & Harkness, 2009). The terms *hypertension* (HTN) and *high blood pressure* (HBP) both carry the same meaning, as a condition leading to increased risk of cardiovascular illness, and are used interchangeably.

In this chapter, I introduce my interest, as primary investigator, in health promotion among patients diagnosed with hypertension. Discussion begins with the statement of the

problem and philosophical basis for the study. The theoretical framework guiding the study is reviewed. This framework supports the importance for investigating the target population and adds meaning to the PI's ideas and dedication to the scope of nursing practice. A purpose statement, research question, and assumptions are presented along with a discussion of the significance, implications for nursing, and limitations of the findings.

Scope of the Problem

Although HTN may affect people of all races or ethnicities, being a member of the Black population is identified as a risk factor for developing the condition (CDC, 2014). The pervasiveness of HTN among the U.S. Black population is well documented (AHA, 2007; Assaf, Coccio, Gans, & Lasater, 2002; Brown, 2004; Geronimus, Bound, Keene, & Hicken, 2007; Johnson et al., 2011; McClellan & Schlundt, 2006; Patel et al., 2010).

Black adults have the highest rate of HTN, which leads to health disparities in this population. The CDC (2014) reports a prevalence of HTN in Black men at 43% and in Black women at 45.7% compared to White men at 33.9% and White women at 31.3%. The total of men and women regardless of race with HTN in the United States is reported as 34.1% and 32.7% respectively (CDC, 2014). According to the American Heart Association (AHA) (2013c), HTN among Black men decreased slightly in the 2013 statistical data. However, in people under age 45 years, men are more likely than are women to have HTN (AHA, 2013c; CDC, 2014). Reports by race/ethnicity and age categories show that Blacks and 20 to 39 year olds are less likely to be aware of, receive treatment for, and control of their high blood pressure (AHA, 2013c). The AHA (2012) reported a 2008 death rate per 100,000 from HTN of 50.3 among Black males compared to 16.5 among White men. An increase to 51.6 per 100,000 in the Black male death rate was reported in the 2009 statistics (AHA, 2013a). In 2008, the AHA (2012) reported the

major cause of death for Black males was cardiovascular disease (CVD) at a rate of 31.8% among all causes of death in the U.S. population. In 2009, 46,334 Black male deaths were attributed to CVD, constituting 31.7% of all causes of death (AHA, 2013a).

Increasing Prevalence

The trend for developing hypertension in Black males increased by 5.5% from 1988 to 2008 (AHA, 2012), an increase that should cause concern among healthcare providers. The occurrence of untreated, uncontrolled, and often-unknown HTN contributes to racial disparities in adult mortality (Geronimus et al., 2007). It has been almost 30 years since the U.S. Department of Health and Human Services started a task force to develop and implement strategies addressing growing racial and ethnic health disparities (McClellan & Schlundt, 2006). Today, such health disparities continue to be an increasing concern, especially with the increasing frequency of cardiovascular disease.

Public Health Concerns

Jennings-Sanders (2003) reported the need for greater emphasis on preventative care for minorities. She based this need on the fact that Black people are more likely than other minority groups to have HTN, not only in the U.S. but globally as well. Keys (1999) reported that Black people die more often from treatable diseases than do White people. As one of the most prevalent modifiable diseases, HTN is a major public health problem in Black communities, and thus is a significant public health concern.

It is necessary to gain insight into the clinical experiences and subsequent behaviors that influence or discourage health-promoting activities from the point of the initial HTN diagnosis. Exploring experiences at this critical point can provide knowledge for developing best practices that promote positive health outcomes and reduce health disparities.

Lack of Awareness, Treatment, and Control

A recent study, conducted as part of the CDC-funded Racial and Ethnic Approaches to Community Health (REACH) program, identified a high incidence of HTN in adults younger than 45 years (Patel et al., 2010). While the CDC (2010b) reported an increase in HTN awareness among Black men from 1994 to 2004, only 56% were receiving medications and only 30% had their HTN under control. Nursing and medical researchers Hill et al. (1999) reported that young Black men under 50 years have the highest prevalence of undiagnosed, untreated, and uncontrolled HTN. A second seminal study conducted by Hill et al. (2003) sampled underserved urban Black males aged 21 to 54 to determine behavioral and physiological outcomes related to HTN care and control. The interdisciplinary authors reported that the participants had a greater degree of target organ damage from HTN due to the longer duration of the disease with lower treatment and control rates. The long-term effects of untreated and uncontrolled HTN increase HTN-related healthcare costs, disabilities, and deaths.

Health Disparities in the Black Population

Focusing specifically on the Black male population adds to the body of science on minority health and health disparities contributing to the burden of heart disease and stroke. Black males aged 18 to 44 are at a higher risk for developing HTN at an earlier age than are White males (Assaf et al., 2002). Compared to Whites, the longer duration of the disease in Blacks leads to a greater likelihood of developing renal and cardiovascular damage. It is a disturbing fact that the high incidence—greater than 40%—of these complications among Black individuals in the U.S. is associated with a condition that, while incurable, is controllable when properly diagnosed and treated (AHA, 2007).

New HTN diagnoses occur earlier in life for members of the Black population when compared to the White population (Geronimus et al., 2007). A primary analysis of NHANES data conducted to predict the probability of self-reported HTN in Black participants compared to White participants identified differences among races, genders, and ages. Age trajectories of HTN prevalence indicated racial differences. The study included a sample of 3,484 White and 2,017 Black individuals, totaling 5,501 participants (Geronimus et al, 2007). The findings provided evidence of racial disparities in HTN. These researchers noted that the disparities between Blacks and Whites increased through the productive years of those aged 15 to 65. Black women were found to have the highest prevalence of HTN over age 40. Comparatively, Black men had the highest prevalence prior to age 40. Factors contributing to the increased HTN prevalence include socioeconomic level, obesity, and psychosocial stressors. High prevalence and early onset of HTN led to earlier health deterioration and higher mortality rates in the Black population. Knowledge, beliefs, and attitudes about HTN were noted to affect Black males' perceptions, health behaviors, and treatment adherence (CDC, 2010b).

In other research, using a qualitative methodology, Ogedegbe, Mancuso, and Allegrante, (2004) studied 93 hypertensive African American individuals to explore their expectations of medical treatment related to blood pressure management. These researchers found participants had unrealistic expectations about HTN treatment. Findings indicated some participants expected to take their medications only when symptoms were present while others expected the medication to cure their HTN. More research is needed to understand Black males' perspectives about HTN. Such information could be used to help develop best practice guidelines nurses and other health professionals could use to improve this population's health outcomes.

Importance to Health Professionals and Society

My interest in this topic developed as a healthcare professional caring for adults debilitated from the effects of heart disease and stroke often related to uncontrolled HTN. Having been diagnosed with HTN in my 30s, I am aware of the challenges faced by those with this risk factor. Focusing on the Black population is important to society due to their increasing risk for developing HTN. Rose, Kim, Dennison, and Hill (2000) conducted a study to explore the experiences of a similar population living with HBP. These researchers selected 19 Black males between the ages of 18 and 49 because they identified this subgroup as having the lowest HBP awareness, treatment, and control of any group in the U.S. based on three categories: age, race, and gender. Three themes and related concerns emerged from the data analysis: "*personal contexts* (meaning of health, high blood pressure, and treatment); *social context* (living as a young Black male in an urban environment); *cultural context of relating* (patient-provider relationship can make a difference)" (Rose et al., 2000, p. 587). The authors noted that personal knowledge and experience influenced post-diagnosis decision-making. Another influence on health decisions was the need for control. The effects of personal circumstances, concerns and understanding; limited resources, unhealthy lifestyle and negative social effects; and cultural relationships were found to influence post-diagnosis adherence to a treatment plan. In the clinical setting, healthcare professionals may fail to consider a patient's knowledge, attitudes, beliefs, and experiences when recommending a treatment plan.

Medication Compliance Concerns

When medications are part of a treatment plan, additional factors may influence adherence. One study found that poor understanding at the point of diagnosis could be a major factor in adherence to a recommended medication regimen. In the United Kingdom, researchers

conducted a study with detailed interviews exploring patients' decisions about taking their antihypertensive medications (Benson & Britten, 2002). They found that some people are non-adherent due to their reservations about taking drugs. Others without such reservations may decide to take their medication based on how they feel. Some people may believe that once they have taken the medicine and begin to feel better, they are cured. Misconceptions of this type underscore the need for personalized discussions to verify patient understanding at the point of diagnosis and in follow-up visits, when necessary. Adherence to a treatment plan also can depend on social, economic, and personal circumstances (Rose et al., 2000). Personal circumstances include issues of privacy, beliefs and attitudes, as well as willingness to accept help from others. Socio-economic conditions such as limited resources resulted from the lack of employment or employment without benefits. Without resources, choices for treatment adherence were limited due to the high cost of medications, medical services, and often, healthy food choices. Building trust between the healthcare professional and the patient is another important element that can influence the creation of a dialogue that promotes patient understanding and identifying and addressing adherence barriers. In this study, exploring individual experiences at the critical junction of diagnosis and decision-making was essential in identifying what does and does not work in promoting better health outcomes for members of this population.

Statement of the Problem

The problem is a lack of understanding regarding how patients' decision-making process or post-diagnosis choices can be influenced by their perceptions of the clinical experience at the time of diagnosis. No studies were found that explored the perception of the information provided *at the time of diagnosis* and its potential influence to facilitate healthy behaviors

recommended by the treatment plan such as increased physical activity, medication adherence, and diet changes. Without this information, it is difficult to establish best practice guidelines for meeting this population's cultural and gender-specific needs and help improve their health outcomes. Failing to understand the link between the diagnosis experience and patients' post-diagnosis choices may contribute to the rising rates of heart disease and stroke in an already high-risk minority group.

Purpose of the Study

Based on the significance of the problem and the lack of understanding of behaviors and meanings related to being diagnosed with HTN, the purpose of this study was to increase nursing and interdisciplinary knowledge regarding the clinical experience at the time of diagnosis, from the perspective of Black males, aged 18 to 44. This includes gaining understanding about how their life experiences at and after diagnosis may be influenced by that clinical encounter. Interventions such as improving one's diet including reduced salt intake, increasing physical activity, avoiding tobacco, limiting alcohol consumption, maintaining a healthy weight and blood sugar level, managing stress, and medication adherence are standard treatment plan inclusions supported by the AHA (2013b) that newly diagnosed individuals may need to include in their daily routine. Engaging in these behaviors has been proven to aid in treatment and control of HTN. The perception of the clinical experience may be a defining factor on how seriously the recommendations to practice these interventions is taken and acted upon by a newly diagnosed person.

Insight gained from understanding the link between a clinical experience of, and the life experiences after, a HTN diagnosis may be useful for enhancing interventions to address the needs of the Black male population early in their condition. Early intervention will positively

affect their health, while decreasing the risk for future health deterioration related to HTN. While early identification is a key strategy for primary prevention of HTN (USDHHS, 2011), to improve health outcomes it must be followed by responsible action including treatment and control.

Philosophical Perspective

The framework of this study is not positioned by a single perspective but is informed by several traditions, including phenomenology, constructivism, and postmodernism within the context of a nursing perspective. In any field of thought, the philosophical tradition will have evolved from what previously existed (Rodgers, 2005), thus this study was informed by past and present traditions using a relatively new method of qualitative inquiry developed by nurse researcher, Sally Thorne.

Philosophical Underpinnings

The rise of postmodern philosophy ushered in in new traditions of inquiry such as the narrative and interpretive methods. Interpretive description is grounded in naturalistic inquiry (S. Thorne, personal communication, June 17, 2013). The philosophical underpinnings for this research design are expressed in the following statements.

- "There are multiple constructed realities that can be studied only holistically. Thus, reality is complex, contextual, constructed, and ultimately subjective.
- The inquirer and the "object" of inquiry interact to influence one another; indeed, the knower and known are inseparable.
- No *a priori* theory could possible encompass the multiple realities that are likely to be encountered; rather, theory must emerge or be grounded in the data" (Thorne, 2013).

The postmodern shift also gave prominence to the hermeneutic tradition of interpretation (Rodgers, 2005), as well as critical perspectives that consider economic contexts. The cyclical movement from pre-understanding to understanding, known as the hermeneutic circle, provides a process for examining the text obtained between interpreter and originator of the text or knower. Research methods of qualitative research, such as that used for this study, often are informed by these traditions.

Thorne (2008) encouraged the use of diverse perspectives during data analysis to extend interpretation. The iterative processes of reading, listening, thinking, and writing yields an understanding of the phenomenon that reflects the researcher's thoughts and ideas, not just the specific properties the data possess. To explore the potential for a greater depth of interpretation, this study's data analysis involved questioning what other meanings could be present.

Social Constructivism

Qualitative research is an approach useful for exploring and understanding social and human problems (Creswell, 2014). The worldview from a constructivist or social constructivist perspective is typical in this research approach. Using an inductive method such as interpretive description fits well with the need to understand the subjective experiences of Black males recently diagnosed with hypertension. The perspective that their experiences are "socially constructed" through subjective and inter-subjective experiences follows the interpretive tradition generated by such thinkers as Paul Ricoeur and Martin Heidegger (Thorne, 2008).

Nursing Perspective

Although this study was influenced by phenomenology, constructivism, and postmodernism, a nursing perspective was used in all aspects of the research. A nursing perspective is useful for establishing general knowledge that can be used within the profession.

A strong foundation from my 25 years of nursing experience contributed to the inquiry and data analysis of this topic. The disciplinary perspective shapes what is observed in the field, what we see during observation, and what sense we make of the observations (Thorne, 2008). The nursing perspective is a reflection of our culture, education, work experiences, and values, which influence our views of a situation (Meleis, 2012). Four defining characteristics of the nursing perspective are nursing science is a human science, nursing is a practice-oriented discipline, nursing is a caring discipline that encourages relationships between nurses and patients, and nursing is health and wellness-oriented pursuit. The focus of nursing on "the human health experience" (Meleis, 2012) fits with the focus of this study.

Insight and understanding are derived from the subjective experience of the participant, expressed in his or her own words. In the constructivist epistemology, the relationship between the knower and the knowable is highly personal and context specific (Lincoln & Guba, 2013). The nursing perspective provided a lens for establishing a relationship with the knower and interpreting or constructing meaning from the contextual surroundings. This perspective allowed me to establish a professional relationship with participants as they shared their health experiences.

Theoretical Allegiance

Often the theoretical framework reflects a methodology and substantive information to guide data analysis or to frame a research study (Thorne, 2008). For example, symbolic interactionism is often reflective of a grounded theory methodology in the same way that a study of lived experiences often is thought to have a phenomenological orientation. Interpretive description does not subscribe to a social science or other theoretical tradition but rather emphasizes a less specific theoretical fore structure. It also does not require studies to be located

within a specific formal theory. A health and wellness perspective influenced by social determinants was the theoretical fore structure of this study.

The interpretive description approach places strong emphasis on the researcher or PI as instrument (Thorne, 2008). Intellectual exercises within three elements are recommended to obtain clarification and link the theoretical fore-structure of a study. The elements suggested are locating the researcher's theoretical allegiances, locating the disciplinary allegiance, and locating ideas held by the researcher and determining how these elements relate to the research.

Disciplinary Allegiance

Of the three elements, two already have been addressed: the disciplinary allegiance to nursing and the PI's knowledge base from nursing and having high blood pressure. In this study, the nursing perspective will be used throughout the study.

> A nursing perspective is defined by its unique aspects, the history of the profession, the sociopolitical context in which nursing care is provided, and the nature of the orientation of members of the nursing profession, as well as the discipline.
>
> (Meleis, 2012, p. 88).

Nursing is a health and wellness-focused, person-centered, practice-driven, and holistic profession that uses knowledge from research and theories derived in nursing and other disciplines. The nursing perspective informed the development of interview questions and was useful for promoting a professional relationship between interviewer and interviewee during the recruitment and interview process. During data analysis, a nursing lens was used to describe and interpret the data especially for determining implications for nursing and healthcare practice.

Researcher Allegiance

The element of locating my relationship to the ideas and thoughts was addressed in the discussion of my interest in hypertension. Maintaining my nursing perspective guided by the scope and standards of nursing practice, I intuitively hold a desire to help those who have not been given equal opportunities to maintain personal health goals.

Throughout the research, I documented my thoughts and ideas using the processes of reflective and reflexive journaling as recommended by Thorne (2008). This documentation was useful while conducting the data analysis. Anyone participating in the analysis was asked to record their ideas related to the study prior to reading transcripts. All members of the dissertation committee are healthcare professionals; three are in the nursing discipline and one is a medical doctor specializing in cardiology.

Researcher's Theoretical Allegiance

Evaluating perceptions and behaviors related to new diagnoses of HTN addresses a gap in healthcare knowledge that is influenced by the social determinants of health. By completing the intellectual exercises of self and disciplinary reflection recommended by Thorne (2008), this study was informed by the socio-economic model of health (Dahigren & Whitehead, 1991) (Figure 1.1).

The Dahigren and Whitehead Model of Health. This model represents inequalities, possibly preventable, that often affect vulnerable populations. Being a member of a minority group in the U.S. is reported to be a predictor of poor health outcomes (Braveman & Egerter, 2008). Inequities in screening, incidence, treatment, and mortality of cardiovascular disease and other diseases and conditions lead to health disparities (Gehlert et al., 2008). Upstream determinants such as socioeconomic status and environmental/community characteristics are

reported to influence downstream factors of individual risk and behavior, disease and health status. Income and education levels affect both upstream and downstream determinants influencing individual health as well as the quality of services that are available in the community. Braveman and Egerter (2013) attributed poor health in the U.S. to stress, racial and ethnic differences in health, poor childhood experiences, and neighborhood features such as a concentration of poverty as well as the aforementioned income and education factors.

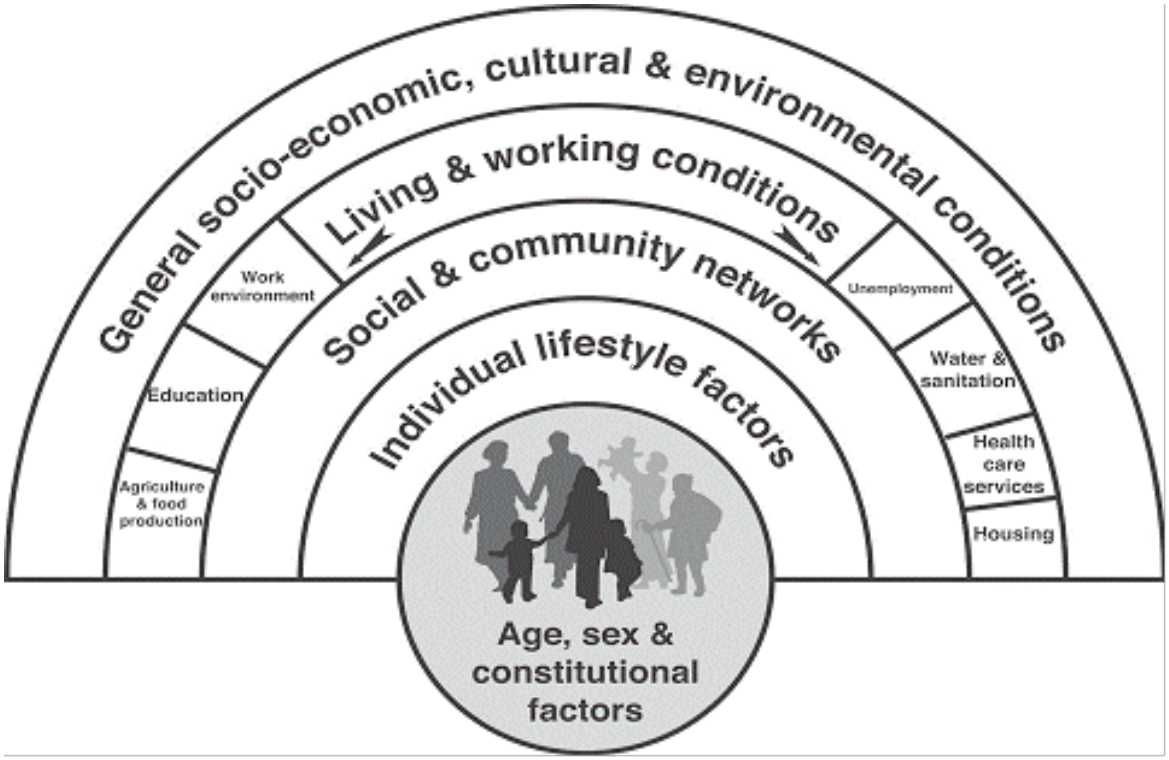


Figure 1.1 Dahigren and Whitehead Model of Health

Source: Dahigren, G., & Whitehead, M. (1991). *Policies and strategies to promote social equity in health: Background document to WHO – Strategy paper for Europe*. Stockholm: Institute of Future Studies.

Black men in the U.S. face many adversities (Teti et al., 2012). When compared to men in other racial/ethnic groups, Black men have a higher incidence of incarceration, unemployment, and of being high school dropouts. Poor health outcomes in this population are influenced by many social and structural challenges. Stressors and sociostructural challenges faced by Black men may include poverty, racism, discrimination, and pressure to project strength or dominance. The adaptations these men adopt to survive in their communities take a toll on their individual health outcomes. The stressful environmental factors and lifestyle behaviors that may be viewed as coping strategies can contribute to unhealthy behaviors. The socioeconomic model of health illustrates these influences as a direct correlation to overall health outcomes.

The model of health encompasses both upstream and downstream health determinants. The broad range of personal, social, economic, and environmental influences interrelate to determine health outcomes in the U.S. (USDHHS, 2014a). Beyond traditional healthcare and public health sectors, the interrelationships among these factors influence the health of individuals and, subsequently, entire populations. The intellectual exercises of exploring my personal ideas and relationship to the topic, theoretical allegiances, and grounding in the discipline of nursing were informed by the health determinants in this model. This knowledge was useful in determining the desired sample population, identifying a geographical area where recruitment would be most effective, developing interview questions, and identifying nursing implications

It has become evident that medical care alone cannot improve overall health (Braveman, Egerter, & Williams, 2011). To improve health and reduce health disparities, where and how people live must be addressed. Upstream factors such as economic resources, education, and racial discrimination influence downstream factors such as health behaviors. In this study,

participants were asked to share their personal experiences and perceptions of related upstream factors. Through analysis of this data, the PI explored how these factors affected participants' health related to HTN.

Research Questions

How do Black males recently diagnosed with HTN describe their life experiences and post-diagnosis health behaviors, when reflecting on their perception of the clinical experiences at the time of their diagnosis? While this main question guided the study, three other questions enhanced interpretation of the findings during data analysis.

- What is the perception of the clinical experience when being diagnosed with hypertension?
- What is the experience of individuals newly diagnosed with hypertension and what choices do they make regarding their treatment plan?
- How do the perceptions of the clinical experience influence adhering to a treatment plan?

Definitions

Hypertension / High Blood Pressure

The American Heart Association (2013b) defines HTN as a blood pressure reading of systolic ≥ 140 mmHg or diastolic ≥ 90 mmHg on two or more readings at least one week apart. Pre-hypertension is defined as a systolic blood pressure > 120mmHg or a diastolic reading > 80mmHg. Pre-hypertension readings indicate a concern for developing high blood pressure, thus may be interpreted by the public as high blood pressure.

Clinical Experience

The clinical experience pertinent to this study is a healthcare interaction where a medical doctor or nurse practitioner identifies blood pressure readings consistent with the measurements

indicating HTN. After examining the patient's health data, the healthcare professional communicates a medical diagnosis of HBP.

Treatment Plan

Instructions or prescriptions developed specifically for the patient and provided to them as a guide for managing their condition constitutes a plan to treat HTN. A treatment plan can include, but is not limited to, recommendations for diet changes, increased physical activity, smoking cessation, limiting alcohol, weight loss and/or maintenance, and medication adherence. Treatment plans are individualized to persons receiving the care.

Health-Promoting Behaviors

Health-promoting behaviors include the recommended guidelines for treatment and control of HTN such as consuming a better diet with reduced salt intake, regular physical activity, avoiding tobacco products, limiting alcohol consumption, maintaining a healthy weight, managing stress, understanding hot tub safety, and complying with medication adherence as directed by a healthcare professional (AHA, 2013b).

Assumptions

Assumptions regarding being diagnosed with and living with HTN were derived from my experience as a registered nurse and from the scholarly healthcare literature concerning lifestyle behaviors of individuals diagnosed with HTN.

- Adults diagnosed with HTN may experience mental, physical, and/or emotional stress related to their diagnosis.
- The social influences of family and friends can discourage or facilitate health-promoting behaviors in adults with a new HTN diagnosis.

- Healthcare providers have limited time to spend with patients newly diagnosed with HTN.
- Adults with HTN can reliably recount events related to their diagnosis, especially regarding their subjective perceptions of those events.
- There are sociocultural differences in the experiences of some Black males compared to other groups in seeking healthcare.

Limitations and Delimitations

When human beings are used as the instrument for gathering data of subjective experiences, steps should be taken to account for potential problems that are beyond the researcher's control. The potential for biases from the researcher and participant perspectives was a consideration for this study (Creswell, 2009). While researcher bias may be introduced at any time during a study, the probability increases during the data analysis. Steps were taken to reduce researcher bias for this study through the use of recommended strategies such as reflective and reflexive journaling, triangulation of analysis, and credibility checking.

Participant bias may be introduced when interviewees are responding to questions. Consideration was given to the fact that participants may offer responses they think the researcher wants to hear, not what they actually perceived. Awareness of influences, including racial and gender differences between the PI and participants that cannot be controlled also added to the findings' credibility. While study limitations often are viewed as weaknesses, the strengths of qualitative research—such as gaining historical information and a subjective perspective—can outweigh the conditions that influence the findings.

Limitations

Replicability is a weakness of this research design (Brink & Wood, 1998). Due to subjective nature of human responses, it would be impossible to return to the same participants, ask the same questions, and get the same responses. New experiences can change a person's mind, beliefs, and positions. Researcher individuality also could be problematic when trying to reproduce this study.

When considering generalizability, researchers should consider the likelihood of persons with similar characteristics having experiences resembling those of Black males aged 18–44 who were newly diagnosed with HTN. Perceptions of adult Black males aged 44 and under may not be the same as men greater than 44 years old or of Black females.

Delimitations

The purpose of the study was to understand how the clinical encounter at the time of diagnosis might influence life experiences after diagnosis. Setting boundaries to achieve this purpose included making decisions regarding the sample, method, and data collection procedures. Focus on a single culture and gender provides a deeper understanding of an understudied population. Being Black increases the risk for developing HTN, thus including females in the study would provide a broad look at the phenomenon. However, women's perspectives of health can be very different from the male perspective as noted in the literature. Conducting private face-to-face semi-structured interviews to elicit the subjective stories from the male perspective allowed participants to speak freely without the peer pressure that may be present in a focus group setting. This method of data collection provided consistency in the questions asked and allowed participants to give their own story rather than just *chiming in* with

others. Using specific criteria (inclusions and exclusions) to select the sample further defined the population boundaries.

Significance of the Study

Exploring the subjective experience of Black males diagnosed with HTN related to their perception of the clinical experience at the time of diagnosis allows for increased understanding of the patient and clinician interaction. During this interaction, participants may have discovered compromises and responsibilities related to their health behaviors that affect the manageability of their condition. One study purpose was to identify which interaction factors promoted acceptance of the personal responsibilities related to HTN. The individual perception of experiences surrounding the diagnosis and treatment can influence long-term goals that ultimate affect health outcomes.

Nursing

Paschal, Lewis, Martin, Dennis-Shipp, and Simpson (2004) reported on the low participation of Black males in health-promoting research, which highlights the limited knowledge related to this high-risk population. The paucity of literature on the health-promoting behaviors of the Black population in general is cause for concern. Adding to the body of science in this area is necessary for promoting health and reducing health disparities for this population.

Healthcare professionals can benefit from being informed of the growing prevalence of HTN, and researchers should support efforts to address this need. Understanding perceptions of the clinical experience and subsequent health behaviors can assist health professionals in working with members of this population to improve health outcomes. Understanding participants' perspectives can help nursing professionals enhance practice methods for

addressing HTN in newly diagnosed Black males. Any improvement in HTN treatment and control can improve quality of life and potentially reduce healthcare costs.

Health

To improve health outcomes, the CDC (2010a) recommends the development of population-based interventions and strategies that focus on an identified population such as an age group or geographical area. Exploring members of the Black population in the specific age range of 18 to 44 can inform healthcare professionals about enhancing the cultural sensitivity of the interventions they provide. In addition, it is hoped that such findings can be generalized to adults in other populations with similar characteristics.

This study can raise providers' cultural awareness and sensitivity during the critical point of diagnosis. The literature identified contributors to the increased risk of HTN in the Black population, that can apply to any adult at some point in their life, including the high incidence of obesity, poor diet, and lack of physical activity (Assaf et al., 2002; Paschal et al., 2004; Patel et al., 2010). Understanding clinical perceptions can provide insight for addressing these factors with any adult with an HTN diagnosis who requires modifications to promote personal health.

Policy

Building evidence-based measures into effective programs that promote positive health outcomes is crucial in the current health environment. The Healthy People 2020 goals include promoting evidence-based measures to influence community health (USDHHS, 2011). Gaining knowledge and understanding related to HTN has the potential to enhance practice and influence policy decisions.

Best practices for treating HTN may include all of the aforementioned interventions such as medication adherence, diet, exercise, and other behavior modifications. Nevertheless, no

researcher reports were found connecting interventional challenges with existing cultural and gender preferences. For example, clinical trials have demonstrated that pharmacological and non-pharmacological HTN treatments can lower blood pressure and, in many cases, control the condition (Hill et al., 2003). However, social barriers and perceptions of affordability may make some measures unrealistic for some patients. An effective interdisciplinary approach sensitive to cultural and gender needs is vital for developing knowledge to help individuals implement and advance health-promoting behavior leading to improved health outcomes. Seeking understanding from the perspective of specific populations can clarify and add to the existing body of knowledge. Results of this study also may have policy implications for public health services, including public health nursing practice.

Conclusion

This study explored the subjective experiences of Black males diagnosed with HTN. The high prevalence and increasing statistical reports of death and disability in the population provided a strong basis for conducting this study. Using a nursing perspective during data collection and analysis assisted in the development of culture- and gender-specific knowledge that may help improve healthcare practices for Black male adults with HTN. Along with medical cost savings, the possible societal benefits of this research include the potential to improve health, decrease disability, and improve workforce viability for this population. In an economically stressed health environment laden with health disparities, targeting health behaviors to vulnerable population with a high incidence of HTN prevalence can benefit more than those who participated in and learned from this study. The results of this and future related studies may allow health initiatives to be addressed and adjusted to increase their efficacy. This

also can inform future studies in this population and provide a platform for conducting studies of other populations with similar problems.

Chapter Two: Literature Review

Introduction

A review of the literature identified a lack in nursing knowledge about the clinical experiences of adults recently diagnosed HTN and their choices regarding the health promoting behaviors recommended for disease maintenance and control. Few reports were found that addressed the health-promotion activities of Black adults. Specifically, few studies reported how people responded to a new diagnosis. No reports that addressed the newly diagnosed Black male with HTN were found. To validate the paucity of literature focusing on Black men, Newton, Griffith, Kearney, and Bennett (2014) conducted a systematic review of weight loss, physical activity, and dietary intervention of African American men. They found that only 14 out of 141 eligible papers included outcomes for this population. Of these 14, only four studies focused specifically on African American men. Additionally, when Black or African American men were the focus of a study the average participant age generally was over 44, thus confirming the need for this research on an understudied population: young, Black males.

Not only is evidence focusing on the study population lacking, there also is a significant absence of literature regarding best practices for enhancing health promotion behaviors that address the specific cultural or gender needs of a population with HTN. This chapter briefly overviews HTN concerns and predictors and presents the prevalence of HTN in Black adults. A discussion of health promotion and barriers to health promotion within the Black male population is included. Clinical-practice guidelines for preventing, detecting, evaluating, and treating HBP also are discussed, followed by recommendations for sociocultural and gender-appropriate interventions useful in healthcare practice. A discussion about the benefits of

motivating patients with HBP by meeting their cultural and gender-specific needs validates the idea of focusing research on an understudied minority population with HTN.

Review of the Literature

The literature identified research reports that addressed HTN prevalence as well as the perceptions and behaviors of Black/African American adults diagnosed with the disease. Researchers used the title African American broadly. It is believed that the population identified as African American has the characteristics of persons identifying themselves as members of the Black population. For this review, the identifier, *African American*, refers to the same people identified as Black.

Statistical findings reported in the literature demonstrate how HTN's early detection, treatment, and control rates for Black men and women compare with those of adults from other populations. Research includes studies focusing on interventions for targeting hypertension. Recommendations for developing interventions targeting underserved populations, such as the population targeted by this study, also are noted.

Search criteria included several key words: *African American, Black males, men, hypertension, blood pressure, clinical diagnosis, clinical experience,* and *health promoting behaviors.* Single words and word combinations produced a significant number of studies. Databases accessed included CINAHL, PubMed, the Cochrane Library, and Google Scholar.

Concerns and Predictors of Hypertension

High blood pressure is a major public health concern. Complications from HTN/HBP can lead to heart attacks, stroke, kidney disease, eye problems, brain disease, sexual dysfunction, bone loss, and sleep disorders (Mayo Clinic Staff, 2011). The high incidence of HTN in the Black population compared to the White population results in a higher prevalence of

cardiovascular disease in Black people compared to White people (Fuchs, 2011). Black adults have persistently suffered from higher rates of HTN acquired earlier in life than have White adults (Hicken, Gragg, & Hu, 2011). The increased prevalence results in higher health costs and mortality rates among the Black population.

As age and HTN prevalence increases, the control rate decreases (Lackland, 2009). In their attempts to uncover the causes of this often preventable and controllable disease, researchers have looked at many human characteristics, from behavioral patterns to genetic markers. Consequently, researchers have documented racial disparities in HTN prevalence and related health concerns.

Anthropometrics and Fat Patterning

Body size from childhood through adulthood has been strongly associated with HTN. Research studying the correlation of excessive weight or high BMI as predictors of HBP often includes baseline data of weight and/or body mass index (BMI) (Apostolides, Entwisle, Ouellet, & Hebel, 1978; Assaf et al., 2002; Geronimus et al., 2007; Paschal et al., 2004; Patel et al., 2010). Anthropometrics (the measurement and comparison of human body proportions) and fat patterning, however, do not explain the racial discrepancies associated with blood pressure (Lackland et al., 1992). Researchers suggest that genetic and environmental factors present throughout a lifetime may be more predictive factors for developing HTN than BMI and body fat patterns.

Environmental exposure and habits have been proposed as contributing to the higher prevalence of HTN in Black people compared to their White counterparts (Fuchs, 2011). The effects from "socioeconomic status, dietary habits, social network, stress, and health behaviors" (Fuchs, 2011, p. 379) are believed to play a role in increased HTN in the Black population.

Excessive adiposity from cultural dietary habits is reported as a factor contributing to the 51% higher HTN rate in Black people compared to White people. However, for Black men, obesity is reported to account for only 24.9% of their HTN problems (Fuchs, 2011). Thus, HTN predictors and contributors in the Black population remain an area for future research and discovery.

Genetic Predictors

The National Institutes of Health (NIH, 2009) published two international studies conducted to pinpoint genetic variants associated with HBP. One study specifically targeted the African American population. Deoxyribonucleic acid (DNA) samples were analyzed from 1,017 African American men and women (Adeyemo et al., 2009; NIH, 2009), half of whom had HTN. From 800,000 genetic markers—called single-nucleotide polymorphisms (SNP)—the researchers found five genetic regions with SNPs that were significantly associated with systolic blood pressure. No genetic markers were found to be associated with diastolic blood pressure or a combination of systolic and diastolic blood pressure. The five regions associated with systolic blood pressure were near genes that code for proteins. These proteins already were believed to affect blood pressure. Additional research revealed that all five genetic markers likely are involved in the biological pathways related to blood pressure and HTN. Current pharmacological treatment for HTN includes the use of calcium channel blockers, which target one of the identified variants. A follow-up study replicated some of the significant SNPs in a sample of 980 West Africans, with and without HTN. The follow-up analysis showed that some of the genetic variants also were present in this population.

Research on genetic predictors is a step forward for enhancing treatment and control. Early identification and prevention measures are vital for reducing HTN prevalence. In addition, efforts to gain knowledge about populations at high risk for developing the condition can

influence practice interventions for early motivation. Such efforts also may help improve health outcomes in a population burdened with health disparities.

Socioeconomic Influences

Socioeconomic status and the effects of sociostructural stressors affect the health outcomes of racial/ethnic groups (Braveman & Egerter, 2013; Braveman et al., 2011; Teti et al., 2012). Social disparities—such as living conditions, health access, economics, and education—perpetuate stereotypes that can lead to discrimination or racial bias (Barksdale, Farrug, & Harkness, 2009). Anger, sadness, and frustration in response to discrimination are reported to affect health. Although perceived racism was found not to increase blood pressure, it should be studied, especially with the known effects of socio-structural stressors. Stress from racism-related vigilance was measured in relation to HTN prevalence (Hicken et al., 2014). Study finding indicated an association between increased HTN risk and anticipatory stress or racism-related vigilance. Members of the Black population were found to have the highest vigilance levels reported in the study.

Prevalence and Effects of Hypertension

Researchers have studied the prevalence of hypertension by gender, race, and geographical area. Each of these foci provides insight into the health disparities found in the United States. According to NHANES data, HTN is on the rise in the U.S. (Hertz, Unger, Cornell, & Saunders, 2005). It is well documented that Black persons carry the highest incidence of the condition (AHA, 2013a; CDC, 2014; Hill et al., 2003; Ogedegbe et al., 2004; Patel et al., 2010; Peters, Aroian, & Flack, 2006)

Prevalence by Geography

Blaha, Kusz, Drake, and Elasy (2006) reported on HTN prevalence in north Nashville, Tennessee. The population in this region of the city is 85% Black. Members of this population are known to suffer increased cardiovascular mortality compared with White people in Nashville and around the country. Researchers conducted a community-based BP screening survey at a local celebration of Black freedom, education, and achievement. One hundred and thirty-two Black adults aged 18 and older participated in the screening. Education on HTN and individual consultation was provided to participants identified with pre-hypertension or HTN. Pre-hypertension was identified in 29.6% of the participants, while 53.3% of participants were hypertensive. In addition, 17 hypertensive patients, or 12.9% of the participants, had HTN measured at ≥160/100 mmHg (Blaha et al., 2006).

One third of the study's hypertensive patients were unaware of their HTN (Blaha et al., 2006). Age served as the only predictor of HTN. The results showed increasing age resulted in higher odds of being hypertensive. Compared with those under age 30, the probability for developing HTN increased by 1.88 for participants aged 30 to 45; by 2.94 for those aged 45 to 60; and by 7.74 for those older than 60. Race-specific prevalence in the north Nashville area exceeded NHANES prevalence statistics. These findings showed that national prevalence statistics might not represent populations in all geographical areas.

Prevalence by Race

The Nashville Racial and Ethnic Approaches to Community Health (REACH) 2010 was a similar project conducted in the same area. The CDC-funded study included a sample of 3,543 participants at a community health screening for diabetes, HTN, and hypercholesterolemia (Patel et al., 2010). Demographic variables on participants with HTN (N = 2,830) identified the

condition present in 83% of Black and 17% of White participants. The higher prevalence of HTN reported for members of the Black population was consistent with AHA (2013a) data. The high prevalence of HTN in the Black population contributed to the recommendation to include being Black as an additional risk factor for developing the condition. Other factors that contributed to the development of HTN were family history, advanced age, being overweight and/or obese, excessive alcohol consumption, lack of physical activity, poor diet (excessive salt intake), and gender-related risk patterns (AHA, 2013b).

Prevalence by Age and Gender

The AHA (2013b) defined gender-related patterns using the statistical data supporting gender-specific fluctuations in prevalence related to increasing age categories. The statistics indicate that men have a higher prevalence of HTN until age 45. Between ages 45 to 64, gender rates of HTN are similar. After age 64, women are found to have the higher percentage of HTN. In addition to men having the highest prevalence of HTN before the age of 45, Black men are reported to acquire HTN earlier in life, which results in a longer duration and often a greater degree of target organ damage (Geronimus et al., 2007; Hill et al., 2003).

Age prevalence. A primary analysis of NHANES data conducted by Geronimus et al. (2007) used multiple-logistic regressions to predict the probability of HTN in Blacks compared to Whites. The study included a sample of n = 5,501 participants of whom n = 3,484 White and n = 2,017 Black. The research team reported that age trajectories of HTN prevalence indicated racial differences. It was noted that the disparities between Blacks and Whites increased through the productive years from age 15 to age 65. Black women were found to have the highest prevalence of HTN from age 40 onward. Black men, comparatively, have the highest prevalence before age 40. Contributing factors include socioeconomic level, obesity, and psychosocial

stressors. High prevalence and early onset of HTN can lead to early health deterioration and higher mortality rates in the Black population.

Gender prevalence. Gender differences have been reported in factors contributing to HTN. Known factors of excess weight gain and the lack of participation in physical activity have been studied to evaluate gender differences of Black adults. One nursing researcher examined gender differences in the lifestyle behaviors of a sample of Black persons in the U.S. (Johnson, 2005). The sample of 223 participants was almost equally proportioned, with 48% males and 52% females. The study indicated that women were more likely than were men to be concerned for their health. Women were reported to be more likely to seek healthy food choices. The study also showed that women engaged more frequently in health programs, particularly when doing so involved interacting with other participants. Covariates of education and income were noted to influence the health-promoting behaviors of both genders. In conclusion, socio-demographic factors of education and marital status had the greatest influence on lifestyle behaviors, even more than gender.

Lifestyle behaviors. Poor lifestyle behaviors are known to contribute to developing HTN. A study evaluating the health status and behaviors of a sample of Black persons in the U.S. concluded that obesity is a serious problem in this population (Paschal et al., 2004). The participants (n =134) completed a health survey and participated in health screenings to obtain measures for height, weight, blood glucose, blood pressure, and cholesterol levels. Hypertension was identified in 74% of the male and 57% of the female participants. Participants ranged in age from 20 to 74, with 55% having a household income of $30,000 or less. Although the statistics on the percentage of males by age category were not provided, the findings supported the previously discussed gender-related patterns. With reported high obesity rates, poor dietary

consumption, and detrimental lifestyle behaviors, Black males have an increased tendency to develop HTN.

Although both studies included representation from each gender for comparison purposes, Galdas, Cheater, and Marshall (2005) argued that gender-comparative studies are not suitable for drawing conclusions on men's health-seeking behaviors. They suggested that investigations to understand men should not be left to the differences between genders. Understanding the variability between men alone can provide rich data and add to the body of scientific knowledge. Examining men's beliefs, differing backgrounds, varied socio-economic status, and ethnicity is key to gaining an understanding of the triggers and barriers associated with males' health seeking and health promotion behaviors.

Health Promotion

Health promotion dates back to ancient Greeks who lived between the sixth and fourth centuries B.C. (Tountas, 2009). Philosophically, the Greeks believed that behavior within physical and social environments determined their health status. These philosophical speculations became enmeshed with medical beliefs, which lead to the development of skills and community support for physical and social environments, the introduction of public health policy, and the reorientation of health services toward health promotion.

When discussing the relationship between nursing and health promotion, McCullagh (2009) stated, "Health promotion is a concept well suited to the needs and interests of nurses and their clients" (p. 291). Nurses have many opportunities to demonstrate interventional skills as educators, motivators, and health-promotion advocates in a variety of settings. With the focus of medicine shifting from illness management to chronic-disease management, health promotion has become vital to improving health outcomes. Nurses are challenged to design and provide

high-quality health promotion services that decrease healthcare costs while adding quality years to individuals' life spans (Pender, 2011).

Deviations from Health Promoting Behaviors

Sedentary lifestyles. Black adults have a higher incidence of being overweight than their White counterparts. Paschal et al. (2004) recruited 134 African Americans from a low-income, urban area in Kansas to participate in a community-based health education and physical fitness program. Participants were paid $150 over a nine-month period to attend educational classes and at least two physical fitness sessions per week. The researchers reported 55 to 75% of Black Americans rarely exercise. Study results indicated that 79% did not participate in at least 20 minutes of exercise three days a week and 49% did not consume fruits and vegetables regularly. Of the 40 Black males in the study, 74% had HTN. These findings indicated that sedentary lifestyles and poor dietary practices led to an increased risk for HTN. The researchers recommended community-based interventions to slow the rate of excess weight gain and increase physical activity, in order to reduce risk factors in this population.

Low fiber intake. A recent study of dietary fiber intake across sex, age, race/ethnicity, family income, and poverty threshold showed that non-Hispanic Blacks have a significantly higher body mass index (BMI) than White and Hispanic individuals (Storey & Anderson, 2014). In addition, Black males aged over 20 years had significantly lower dietary fiber intake than White and Hispanic males. Non-Hispanic Blacks also reported lower levels of education and more households living on less than $25,000 per year than White people. The study concluded that lower family income and living at less than 131% of the poverty level were associated with lower dietary intakes among adults. This association indicates that low income Black Americans often may not consume the recommended daily dietary allowance. Dietary intake of fruits and

vegetables are associated with cardiovascular health. Increasing dietary fiber promotes the concentration of fatty acids important for immune regulation and gut health. Increasing dietary fiber intake can be especially beneficial for some Black people, who report eating a diet high in fried, fatty foods.

Alcohol consumption. Heavy alcohol consumption contributes to the development of HTN (AHA, 2013b). Chartier, Hesselbrock, and Hesselbrock (2013) conducted research comparing ethnicity and gender health consequences of adults with alcohol dependency. The researchers found Black men to have a greater prevalence of frequent, heavy drinking than White men. A relationship was reported between adverse health consequences and heavy drinking, especially when depression was present.

Smoking. Tobacco smoking is another behavior reported to influence the development of HTN. The use of tobacco products is associated with adverse effects on the cardiovascular system. Research has shown a decrease in the development of HTN and cardiovascular events among non-smokers and former smokers. Nordahl et al. (2014) showed that socioeconomic position, smoking, and HTN increased the risk for ischemic and hemorrhagic stroke. Previously mentioned studies reported that Blacks have a higher prevalence of HTN and many live in lower socioeconomic levels than do Whites. According Nordahl et al. (2014), there is an increased risk for HTN among Black men who smoke.

Culturally Sensitive Behaviors

Kennedy et al. (2007) conducted a focus group intervention to examine the cultural characteristics of Black Americans related to health promotion behaviors. To encourage discussion, the researchers asked questions about religion, family, health beliefs and practices,

work ethic, education, economics, authority figures, clothing, entertainment, food, and communication.

The study indicated that religion, family, and education were valued as the keys to success (Kennedy et al., 2007). Historical perspectives of money, work ethic, and the relationship between people of color and members of the White population had unpleasant connotations. Participants reported being limited by low socioeconomic levels, which prevented health-promoting behaviors such as joining a gym or making good food choices. Many saw that their ethnic identity-marker of consuming "soul food" (Kennedy et al., 2007, p. 551) could affect their health status. Soul food, as defined by Merriam-Webster (2013), includes foods that are high in fat content by nature or preparation method, such as chitterlings, ham hocks, and collard greens.

In another focus group study, discussed further in the next section, participants reported engaging in a church-sponsored heart health awareness program. Focus group participants shared an example of cultural influence as they reported that church members participating in a two-mile health walk celebrated by consuming a meal of fried chicken, macaroni and cheese, biscuits, and greens with ham (Peters et al., 2006). Such food preferences often are embedded in Black cultural norms, and some Black persons may feel social pressures within their culture to consume these types of foods.

Culturally Sensitive Attitudes and Beliefs

Using five focus groups, Peters et al. (2006) conducted a study to understand the attitudes and beliefs that members of the Black population have about HTN prevention. Many of the beliefs had been "passed down from generation to generation" (Peters et al., 2006, p. 842) and were formed through the past health experiences of parents and grandparents who shared their

often unfavorable perceptions of illness and interactions with medical personnel. For example, when blood pressure measures fluctuated between medical visits, members began to distrust the medical personnel because of the perceived inaccuracy of their diagnosis. Healthcare experiences perceived as bad influenced participants' general attitudes toward health.

Being accountable to other members of the Black community was viewed as the desire to set a better example by assuming the responsibility to make healthier choices (Peters et al., 2006). Participants demonstrated awareness of and even the desire to practice prevention through health-promoting behaviors. A barrier to fulfilling this desire was expressed as being perceived as "acting different" (Peters et al., 2006, p. 846). When one member of the population openly practiced healthy eating and subsequently began to show health benefits such as weight loss, the person was subjected to scrutiny from others in the population. One participant shared the experience of being told she was "acting White" (Peters et al., 2006, p. 846). She viewed this remark as an insult that labeled her as different from others in her culture. The need to be accepted and supported by family and friends within the culture can override the desire to promote health when it conflicts with cultural beliefs.

Barriers to Health Promotion

In other studies of Black Americans, researchers reported access to care, disease prevalence, quality outcomes, prevention, and prevalence of risk factors as obstacles to controlling HTN (Jennings-Sanders, 2003; Tumiel-Berhalter, Kahn, Watkins, Goehle, & Meyer, 2011). The Nashville REACH findings group barriers to healthier living into three categories: personal, environmental, and systemic factors (Miller et al., 2004). Lack of adequate finances, physical limitations, lack of knowledge, stress, lack of healthy food choices, and inadequate places to exercise can hinder efforts to promote good health outcomes.

In addition to those mentioned above, another study identified additional health barriers faced by Black men: masculine behavioral expectation, experiencing racism, religious beliefs, and peer influences (Cheatham, Barksdale, & Rodgers, 2008). The number and complexity of the barriers facing this population result in many challenges for the healthcare professionals who treat them. Research that identifies positive influences that lead to improved health outcomes for Black men can help eliminate some of these challenges.

Health Perceptions

Black men face many health problems that result in excessive death rates, declining life expectancy, health disparities, and fatalistic views of health outcomes (Mount et al., 2012). Researchers identified five themes in Black men's health perceptions: "lack of chronic disease awareness, fatalism, fear, and anxiety of academic-medical settings, hyperactive masculinity fatigue, and the gay-straight divide" (Mount et al., 2012, p. 71). The men lacked awareness of chronic disease until it affected someone close to them. They fatalistically believed in their potential for developing a chronic disease or early death, regardless of how healthy their behavior was. The perceived sociocultural and interpersonal disconnect with the academic-medical setting led to fear and anxiety, which resulted in mistrust of the medical profession. From these men's perspective, masculinity was demonstrated through acts of courage, physical prowess, and invincibility (Mount et al., 2012). The men believed that heterosexual and homosexual males were not treated equally in addressing health promotion activities. Understanding and addressing patients' health perceptions while helping them cope with an HTN diagnosis can be challenging for healthcare professionals. However, addressing these perceptions during the clinical encounter at the time of diagnosis can be part of early intervention and treatment, which can improve health outcomes.

Enhancing Clinical Practice

Once a client is diagnosed with HTN, a healthcare professional determines the appropriate treatment to address specific patient needs, which can include counseling, support, and follow-up. The Joint National Committee (JNC) of the U.S. Department of Health and Human Services (2003) provides best-practice guidelines for preventing, detecting, evaluating, and treating HBP. Along with medication guidelines and lifestyle modifications, the committee's primary recommendation is motivation. The JNC report indicated that effective therapy could be achieved only if the patient is motivated. Empathy is identified as a way of building trust to encourage motivation. Therefore, providing a pleasant clinical experience is a vital part of encouraging improved health outcomes.

The AHA, an excellent resource for healthcare professionals and patients, provides information about HBP via their website and printed brochures. It is not known if or how AHA information is used by healthcare professionals for patients newly diagnosed (Patel et al., 2010). Exploration identifying how and when this and other evidence-based information is used in the practice environment could be beneficial to future patients diagnosed with HTN.

Health Communication

Thorne et al.'s (2013) study of communication in cancer care reported three types of poor communication: ordinary misses, systemic misunderstandings, and repeat offenders. Persons being diagnosed with HTN are prone to similar communication problems. In another study, Thorne et al. (2010) noted that the time of diagnosis *set the stage* for how the diagnosis would be experienced. This places a great deal of responsibility on the HCP during a time when the patient's readiness to learn may not be adequate to understand the treatment plan.

A recent study conducted by Ogedegbe et al. (2014) tested an intervention that included patient education, home blood pressure monitoring, and monthly lifestyle counseling. Compared to usual care, in which HCPs provided written material and HTN guidelines, there was no difference noted in the rates of controlled blood pressure. However, Victor et al. (2011) reported a significant improvement in HTN control using a barbershop-based intervention for Black men. This comparison indicates education and communication at the community level may provide greater benefits for the Black population. Being aware of potential barriers of literacy, culture, language, and physiological factors will help HCPs determine the appropriate approach for delivering health information, especially when communicating a new diagnosis (Beagley, 2011).

Understanding Risks

A single study exploring how persons newly diagnosed with HTN understand the risks of the condition has been found to be meaningful for healthcare professionals (Weaver, Murtagh, & Thomson, 2006). A sample of six women and five men, aged 41 to 82, agreed to participate. The narrative study revealed two categories of risk understanding: denial and acceptance. HCPs were asked to consider including patients' ideas, fears, and expectations in their discussions with them. The HCP use narratives at the time of diagnosis to promote patient understanding of risk-coping strategies. Observing patients' verbal and nonverbal cues can help HCPs assess their level of understanding (Beagley, 2011). Developing a strong patient-provider relationship can promote communication that leads to improved understanding. To enhance their practice and improve health outcomes, health workers need to identify interventions that promote motivation, encourage relationship building, and help the patient cope with a new diagnosis.

Focusing on the Black Male Population

Research focusing on Black males with HTN allows for exploration of key issues faced by this population. Seminal nursing research conducted by Hill et al. (2003) included a randomized controlled trial with 309 hypertensive Black males. Participants, aged 21 to 54, in the experimental group (n=157) received an intensive educational-behavioral-pharmacological intervention. The control group (n=152) did not receive the intervention, but instead were referred to community resources that provided HTN care, allowing them to seek education and support on their own. The control group received follow-up calls every six months to check on their health status. At the end of the 36-month study, the experimental group showed a greater reduction in blood pressure and higher rates of HTN control. The study also looked at the variables of illicit-drug positivity, tobacco smoking, high sodium diet, obesity, and excessive alcohol intake. Improvements were found in two lifestyle risk factors—smoking and sodium intake—while the other risk factors remained unchanged for both groups. The low intervention group did show some improvement in blood pressure levels. The improvement in the minimal intervention group indicates an annual evaluation, telephone calls every six months, and appropriate referrals to culturally competent and motivated staff can affect health outcomes.

An earlier study with a similar population of Black males (Hill et al., 1999), illustrated the difficulty of recruiting and following members of this population. The intervention—using community health workers to educate and follow up with participants—did not substantially reduce or influence the participants' control of their hypertension.

Early Detection, Treatment, and Control

Early identification of HTN is essential for improving control of the disease, and one of the most effective ways to prevent heart disease and stroke (SurgeonGeneral.gov, 2011). Federal

funding to support the efforts of health promotion programs was distributed in 2011 (O'Donnell, 2012). More than $1 billion in funding opportunities for health promotion was awarded to Medicaid incentive-based strategies, 61 community-level programs, and comprehensive workplace programs. These programs highlight the federal government's commitment to stimulating health promotion efforts in diverse segments of the nation. Key themes of the government efforts were improving health and quality of life for those engaged in the programs, and improving health through lifestyle changes that promote healthy work environments and reduce the financial burden on Medicaid and Medicare.

Community Health Screening

In evaluating the Nashville REACH 2010 community health screening strategy, the research team asked four questions (Schlundt et al., 2006) including queries into how often participants were found to have undiagnosed HTN or suboptimal management of their HTN. Although the participants were younger and seemingly healthier than was the targeted community population, undiagnosed HTN was found in 17.4% of Black adults. Poorly controlled HTN was found in 39.0% of the population screened. Pre-hypertension was present in 45.3% of the Black participants. The researchers found the screening helpful in identifying persons with HTN and other risk factors. These participants had previously viewed themselves as being healthy or not having any health risks.

In another study using NHANES data, the researchers recommended that screening begin early in life, especially for members of the Black population (Geronimus et al., 2007). The comparison of age trajectories of HTN prevalence between Black and White adults resulted in statistically significant findings that members of the Black population develop HTN earlier in life. The longer duration of the disease promotes a higher incidence of health deterioration,

especially when HTN is uncontrolled. Screening and appropriate diagnosing with clinical education that meets the needs of the population should be planned to address the lifetime challenges facing individuals with HTN.

Health Screenings Primary Prevention

Responsibility for personal health in the U.S. is steadily moving from a reactive to a proactive preventive-care model (Clarke, 2010). Converging trends are driving the responsibility for health to the individual by increasing the transfer of financial costs to them and providing evidence that personal behaviors affect health outcomes. The proactive preventive-care approach is viewed as a logical, cost-efficient alternative to traditional healthcare models. The national strategy for this new model includes community screenings as a primary preventive approach (SurgeonGeneral.gov, 2011). Evidence-based preventive services include screenings as cost-effective or even cost-saving means of preventing disease, detecting health problems early, and educating people to make good health decisions. While the services may be delivered in a traditional clinical setting, other community settings are considered excellent venues for providing effective preventive services. Community services may include health fairs or screenings conducted in churches, community centers, schools, worksites, shopping malls, or even homes.

Interventions to Promote Treatment and Control

A resident health advocate (RHA) intervention was tested in Boston's public-housing sector (Rorie et al., 2011). The purpose of the nurse-led study was to evaluate the effectiveness of mobile health screening. The study included an assessment of post-screening follow-up care for people with positive HTN screening results. Four housing developments with RHAs were selected for the study; two were assigned to the interventional group, and two were designated as

the control group. Participants were recruited for two consecutive summers. The two sites serving as the control group in 2007 received the intervention only in 2008. The findings suggested that an increase in follow-up appointments from 15% in 2007 to 55% in 2008 was influenced by the RHAs. Although screening was conducted on four cardiovascular disease risk factors, hypertension was found to be most common. Of the 64 participants who were positive for HTN, 39 were previously unaware of their condition. It was suggested that RHAs or motivational support could increase appropriate medical follow-up care for persons with HTN.

Nurse-managed Protocols

Chronic disease management in the U.S. is very costly with 75% of healthcare dollars being spent on chronic illnesses (Shaw et al., 2014). Providing affordable, accessible, quality care to a greater number of people with chronic illness might be met by a team approach to care. The use of nurse-managed protocols for the management of chronic conditions such as diabetes, hypertension, and hyperlipidemia may prove to be an effective strategy. Research conducted by Shaw et al. (2014) found positive health outcomes using a team approach.

Community Health Workers

Similar to mobile health screenings, using community health workers (CHW) trained for disease identification and outreach was found to influence improved blood pressure control in a high-risk population (Levine et al., 2003). The targeted population, 800 Black Americans in West Baltimore, was assigned to either an experimental or a control group. Both groups received the low-intensity intervention: home visits by trained CHWs who counseled and educated participants on HTN prevention, treatment, and control. When needed, the community health worker also provided care referral during the initial visit. The experimental group received five additional home visits over a 30-month period. During the additional visits, the CHWs measured,

monitored, educated, counseled, linked participants to services, and made recommendations regarding medicines, diet, and other lifestyle modifications. After 40 months, the percentage of participants with adequately controlled HBP increased from 16% to 36% in the experimental group. The control group also benefited from the low-intensity intervention, showing an increase in the percentage of participants with adequately controlled HBP from 18% to 34%.

Analysis of these findings suggested that interventions do not have to be high-intensity or ongoing to achieve some effect. Small reductions in blood pressure can significantly reduce a population's incidence of CVD (Assaf et al., 2002). Forwarding information about HTN control needs to CHWs can be an effective way to promote control efforts. Interventions tailored to the sociocultural characteristics of the population can improve adherence.

Barbershop Outreach

Local barbershops, a popular venue within most Black communities, have been found to be an effective location for outreach promoting identification, treatment, and control of HTN (Hess et al., 2007: Victor et al., 2011: Wein, 2011). Black males may frequent barbershops more regularly than they visit faith-based facilities. As trusted community members, barbers can help promote education and provide support for persons with HTN. Researchers found barbershop-based outreach in Black communities to be effective for enlisting a large sample of Black males with HTN (Wein, 2011). The comparison study offered blood pressure checks and encouraged follow-up with the physician in nine shops, while patrons were provided with a standard blood pressure pamphlet in eight shops. Hypertension control in both groups improved significantly, yet those who received blood pressure checks and encouragement exhibited a higher rate of control. The researcher suggested that patrons having conversations with the barbers during the

pamphlets' delivery might help motivate them to engage in health-promoting behaviors that result in improved blood pressure results (Wein, 2011).

Religious Support

Although it is thought that Black men frequent barbershops more regularly than faith-based facilities, support and encouragement from religious social support groups in the community may be equally important (Debnam, Holt, Clark, Roth, & Southward, 2012). Researchers comparing the effects of general versus religious support of health behaviors among African Americans found that religious influences gave significant strength and encouragement. It was undetermined whether religious support had greater overall benefits than general social support. Nevertheless, the researchers concluded that religious social support was predictive of some healthy behaviors, such as eating fruits and vegetables and participating in moderate physical activity.

A recent study by Hamilton, Moore, Johnson, and Koenig (2013) explored the effect of spiritual guidance and comfort when dealing with stressful life events. This study's participants were a sample of African Americans located in the southeastern U.S., often referred to as part of the Bible belt. The researchers concluded that men and women used scripture emphasizing God's ability to protect and heal as they encountered stressful health events.

Implications for Nursing and Public Health

Heart disease remains the leading cause of death in the U.S. (Mooney & Franks, 2011; Patel et al., 2010). A reported 30% of U.S. deaths are attributed to heart disease. Screenings for cardiovascular disease alone could help save tens of thousands of lives each year (USDHHS, 2011). Screening and control for blood pressure can help reduce the risk of cardiovascular disease (CVD) by 33% to 50%.

Health Benefits

Researchers reported that hypertension can be controlled with appropriate health behavior changes such as healthy diet choices, maintaining a healthy weight, engaging in physical activity on a regular basis, avoiding tobacco smoke, limiting alcohol consumption, and reducing stress (AHA, 2007; Patel et al., 2010). With Black males having the lowest life expectancy at birth—lower than their female counterparts as well as White men and women—it is important to include Black men in research studies targeting specific risk factors such as HTN. Gaining new knowledge on targeted factors in a specific population may lead to improved health outcomes in an identified high-risk group (Paschal, Lewis, Martin, Dennis-Shipp, & Simpson, 2006). Education and awareness are needed to promote healthy behaviors within the population.

Increased Awareness

Community health screenings and other resources offer opportunities to detect HTN and provide information about heart disease risk factors. Unfortunately, fewer than half of U.S. adults are aware of their risk factors (Whitley, Main, McGloin, & Hanratty, 2011). Failure to control risk factors can precipitate costly emergency room visits, hospitalizations, and preventable deaths. Healthcare professionals can benefit from a deeper understanding of individuals' cultural and gender-specific needs to promote awareness of their HTN risks. The clinical visit at the time of diagnosis offers HCPs a critical opportunity to discuss control and treatment measures with patients (Thorne et al., 2010). Building a patient-clinician relationship is an important component toward communication that will shape the manner of how the patient experiences the illness. Understanding the patients' expectations of blood pressure management is an important first step for educating them about long-term goals and lifetime maintenance. Researchers exploring the expectations of hypertensive African Americans reported that 38%

expected a cure, 38% did not expect to take their medications for life, and 23% expected to take medications only when symptoms were present (Ogedegbe et al., 2004). Education at the time of diagnosis should include the reality of HTN as a condition that requires lifetime management despite often being asymptomatic.

Cost Benefits

Cost savings from improved blood pressure control and prevention efforts can be substantial (Levine et al., 2003). At the community level, preventive efforts can reduce the hospitalizations, emergency room visits, and complications requiring medical intervention, which often result in excessive costs shared by taxpayers. With more people in the U.S. living longer with HTN-related CVD, costs will increase while quality of life may decrease. Pandya, Gaziano, Weinstein, and Cutler (2013) conducted a study of CVD risk factors that supported reducing obesity and improving cholesterol and blood pressure treatments to decrease CVD and its associated healthcare costs. The effectiveness of policies such as the Affordable Care Act will be instrumental to preventing and treating CVD risk factors including HTN. The Million Hearts® Initiative is a partnership of federal and local agencies that, along with its other efforts, promotes access to blood pressure and cholesterol medications. In addition, health information technology can provide patient reminders to improve medication compliance. Innovations and public policies will continue to be major influences on improving compliance in HTN prevention, treatment, and control.

Knowledge about prevention, treatment, and control compliance issues can be gained by understanding the relationship between clinical services and health outcomes. When interventions address sociocultural needs, individuals may be more motivated to engage in health

promotion activities. Using a patient-centered approach instead of a one-size-fits-all approach may improve health outcomes and decrease health disparities.

Summary

Addressing the high prevalence of hypertension in the Black population has become a national and global challenge for healthcare providers. Increased mortality and chronic illnesses in this population lead to greater health disparities, excessive healthcare costs, and decreased quality of life. The increasing death rate of Black males also presents a major concern for the population. Current trends in this population's health behaviors contribute to their increased risk, earlier onset of risk conditions and disease, and longevity of HTN related illnesses. A review of the literature revealed a lack of evidence targeting Black males who have been recently diagnosed with HTN, even though these men have the highest prevalence by ethnicity and gender in persons younger than 45 years of age.

Studies have evaluated the relation between anthropometrics and fat patterning in an attempt to identify predictors for developing HTN. Researchers also have studied genetic markers in seeking answers to the predisposition for the condition, yet there is no conclusive evidence about what factors can definitely predict HTN. However, CDC and AHA health promotion recommendations remain consistent: eat a healthy diet, exercise, avoid tobacco smoke, limit alcohol, and reduce stress. Medical check-ups and follow-up treatment also are important recommendations that Black male adults may avoid if they have negative perceptions, attitudes, and beliefs about medical care.

While studies about HTN prevalence by geography, race/ethnicity, and gender provided insight into the practices of the Black population, a great deal remains unknown. Medical mistrust and false perceptions challenge healthcare professionals who are attempting to build

relationships with persons diagnosed with HTN. Trust is essential for motivating HTN patients' to engage in health-promotion activities.

Human health-promoting behavior is extremely individualistic and may be influenced by multiple factors including socioeconomic stressors. For these reasons, it is not realistic to assume that a single intervention can help every person. The literature strongly supports clinical awareness of sociocultural and gender preferences in developing treatment plans. Understanding the perceptions and beliefs of Black males aged 18 to 44 who were recently diagnosed with HTN can provide new knowledge about their clinical experiences and their post-diagnosis choices. This research has the potential to provide health benefits for the participants, enhance HCP understanding of this population, and result in healthcare cost savings for society. Any reduction in the number of individuals developing chronic illness promotes higher functioning in the community, reduces strain on healthcare services, and decreases healthcare costs.

Meeting the national health goals of prevention and health promotion is a major focus in the current health environment. Gaining the involvement of nurses in the areas of practice, education, and research will be vital for meeting these goals and addressing the other challenges that will confront the healthcare system in the future. This study's findings offer information that may help nursing professionals understand the influence of motivation, work with individuals newly diagnosed with HTN, and reduce persistent racial health disparities in a population vulnerable to HBP. Nurses also could use this study's findings to help them develop and implement effective evidence-based practice in public and community health settings.

Conclusion

This lack of knowledge about the relationship between the clinical diagnosis and the participant's health behavior is one aspect that keeps healthcare professionals from

understanding and implementing practices that could facilitate improved health outcomes for persons newly diagnosed with HTN. Differentiating which interventions are helpful and which are harmful to a patient population is essential for motivating such patients to improve their health. Moreover, offering interventions that are likely to be acceptable to a patient also can strengthen the patient-clinician relationship. A HCP must understand the subjective experiences of Black male adults living with HTN in order to develop appropriate and effective practice interventions. Exploring this population's cultural and gender perceptions during and after diagnosis also adds to the body of scientific knowledge needed to improve current practice.

Chapter Three: Methods

Introduction

An interpretive description qualitative method was chosen as the most appropriate and effective method for addressing the research questions guiding this study. The interpretive description approach often is referred to as a generic method of research (Kahlke, 2014). This approach guides the researcher to move beyond a straight description of the phenomenon to an analysis that seeks to discover associations, relationships, and patterns within the focus topic (Thorne, 2008). Viewing the data collection and analysis through the disciplinary lens of nursing provided a reflective clinical reasoning process that produced a deeper understanding of findings that could enhance future clinical interventions. In this chapter, I discuss the study's method, participant sample, and ethical considerations used to protect participants. The data collection and in-depth analysis processes are discussed along with the steps used to maintain the study's the rigor and trustworthiness

Summary of Method

The interpretive description method is an emerging qualitative method with the flexibility to fit a variety of disciplinary perspectives (Thorne, 2008). By incorporating procedures from other qualitative methods, this method promotes a deep understanding of study data. Thorne (2008) described interpretive description as a strategy for "excavating, illuminating, articulating, and disseminating" (p. 15), knowledge that is of a central importance to an applied discipline. She highlighted the method's ability to extend beyond mere description into the domain of "so what," (p. 33), that often is the driving force for all disciplines (Thorne, 2008).

Using the interpretive description method helped the PI fully explore and identify—rather than merely describe—the experiences of Black males recently diagnosed with HTN. Paired with this method, the research question guided the PI in understanding and interpreting how perceptions of the clinical experience influenced post-diagnosis life choices.

Interpretive Description

The interpretive description method derives its purpose from two sources (Thorne, 2008). The first source is the practice goal. For this study, the practice goal was to enhance clinical practice at the time of diagnosis by understanding a specific population's clinical experiences during this critical time. To identify nursing practice implications, which also may apply to other healthcare disciplines, it was necessary that the study be viewed through a nursing lens.

Interpretive description also derives its purpose from a second source: the desire to determine what is known and not known about a study's focus, based on understanding the empirical evidence. During the interview process, participants provided rich data by sharing the known and the unknown from their perspectives. Interpretive description generates more questions from purpose driven sources, such as this study's guiding questions, which were used during data analysis. This process allows the participants' context to be uncovered in a logical, systematic, and defensible manner.

Further questioning the data extended the study's analysis—beyond assumed knowledge and previously established facts—allowing the researcher to discover the previously unknown. The review of the empirical literature showed that little is known about the experiences of Black males aged 18–44 related to HTN. More specifically, no studies were found exploring this population's perception of the clinical encounter related to their new diagnosis.

Purpose and Research Questions

The purpose of this study was to increase nursing and interdisciplinary knowledge regarding the clinical experience at the time of diagnosis from the perspective of Black males, aged 18 to 44. The guiding question for the study was: How do Black males recently diagnosed with HTN describe their life experiences and follow-up health behaviors post diagnosis, when reflecting on their perception of the clinical experiences at the time of their diagnosis? However, as data collection and ongoing data analysis occurred, it became evident that the stories of the participants included more encounters than the initial clinical encounter at diagnosis. As a result the research question evolved into a much broader scope of influences. The new research question was: How do Black males recently diagnosed with HTN describe their life experiences and post-diagnosis health behaviors, when reflecting on their perception of the clinical experience(s) at and after diagnosis and encounters with family members and friends who share information about living with HTN?

A subset of questions, developed to enhance interpretation, was useful in exploring the data and fulfilling the study's purpose. The subset questions were:

- What is the perception of the clinical experience when being diagnosed with hypertension?
- What is the experience of individuals newly diagnosed with hypertension and what choices do they make regarding their treatment plan?
- How does the perception of the clinical experience influence adhering to a treatment plan?

The interpretive descriptive design allowed the flexibility necessary to use these questions as guides while examining the stories elicited from participants living in a Memphis, Tennessee community.

Human Subjects Research

First, IRB approval was obtained from the University of Tennessee for this study. The plan was made to study Black men aged 18–44 with a HTN diagnosis received at least three months prior to the interview but not greater than one year. To begin recruitment, flyers with the study criteria were distributed to three universities, local malls, community clinics, pharmacies, libraries, barbershops, and other public venues. After almost a month of solicitation, a pilot interview subject was recruited to validate the interview questions. After obtaining informed consent, a demographic questionnaire was completed and the pilot interview was conducted. From this interview, it was determined that duplicate questions should be omitted and additional questions added to investigate participants' understanding of medication effects more fully. Questions were reorganized to allow for a natural flow from topic to topic, as participants shared their stories.

After several weeks of unsuccessful recruitment, it was determined that the participant experience should be increased from living with HTN for three months to one year to living with HTN three months to three years. This change along with the focus of recruiting from a single faith-based setting enhanced recruitment without jeopardizing data quality. A three-year window from the time of diagnosis proved to be more realistic and IRB approval was obtained for the changes.

Setting

All participants except one were recruited from a faith-based food pantry held each Saturday morning. The food pantry served people in a lower socioeconomic suburb of Memphis, Tennessee. It was an orderly process where community members were given numbers to be checked in and their eligibility was verified. All attending the food pantry were processed in the church foyer and seated as groups of 50 in the fellowship room. Here, anyone in the group that demonstrated interest in the study or learning more about HTN received a flyer (Appendix A) about the research study. Persons not meeting study criteria were asked to share the study information with family members and friends who might be eligible. During these interactions, I provided basic information about HTN prevalence and treatments. These sessions served dual purpose of educating people exclusive of the study and recruiting eligible participants. A small clinical room in the back of the fellowship hall provided a quiet location for conducting interviews.

Sample

This study used selective purposeful sampling, a combination of two sampling techniques. Thorne (2008) recommended blending purposive and theoretical sampling, a technique she termed selective purposeful sampling. This technique helped the PI maximize diversity of age in the findings by identifying, through concurrent data analysis, men in the upper and lower ends of the age range who were diagnosed in various settings.

Purposive Sampling

Purposive or purposeful sampling is a technique for recruiting specific individuals by virtue of some angle of experience or phenomenon that all have in common to meet the needs of the study (Powers & Knapp, 2011; Thorne, 2008). Based on this study's purpose, purposive

sampling was an effective strategy for identifying individuals with firsthand knowledge of the study focus who also met the inclusion criteria.

Theoretical Sampling

Theoretical sampling promotes optimal variation in a study's ample. Originating from grounded theory methodology, theoretical sampling works well with concurrent data collection and analysis. By identifying participants with similar experiences, I was informed of qualities not present in the data, as I was conducting data collection, such as varied ages and length of time since diagnosis had occurred. Using this information allowed me to seek participants of other ages and length of time with HTN providing different experiences to broaden the study results. This strategy also helped identify groupings or categories that became evident during data analysis. Although theoretical sampling contributes to theory production in grounded theory research, in interpretive description research, it is mainly used to enrich study data.

Recruitment

Participants recruited from the faith-based food pantry made up the majority of the sample. While one participant was recruited from a lawn company working near the PI's home, he resided in the same Memphis suburb as the majority of participants. One participant was a church employee who lived in another area of Memphis.

With the exception of one telephone screening, face-to-face screening of potential participants was conducted at the recruitment site. Only two telephone calls were received regarding the study during a five-month period. Both callers were screened and were found ineligible as one was female and the other had been diagnosed approximately eight years prior. After the distribution of more than 800 flyers generated only two calls, the PI determined that

being present at the time of recruitment to conduct the face-to-face interview was an effective strategy for working with this population.

Inclusion and Exclusion

Individuals self-identified as Black males aged 18 to 44 with self-reported HTN diagnosed from three months to three years prior were included in the study. Black men older than 45 years or those diagnosed with HTN more three years or less than three months prior were excluded from the study. The determination to exclude potential participants was made during face-to-face conversations at the recruiting site or in the two previously mentioned phone conversations. Participants ranged in age from 23 to 44. Participants received their HTN diagnosis between three and one-half months to three years prior.

Sample Size

Determining sample size in qualitative research is different from quantitative research where mathematical formulas help determine sample size. Thorne (2008) stated that any sample size could be appropriate for interpretive description as the size is best justified by generating a rationale consistent with the research question. She concluded that the majority of studies are relatively small with between 5 to 30 participants. It is reported that a lack of participant knowledge and motivation has resulted in a limited number of research studies involving Black men aged 18 to 44 (Paschal et al., 2004). During recruitment, it was noted that men in this population were not eager to respond to a flyer seeking a research opportunity even when a $25 gift card was given as compensation. The faith-based location provided a location and the time needed to screen and interview participants in one visit. This proved a successful method for interacting with participants.

The objective of qualitative research differs from the quantitative intentions of generalizability; thus sample size should meet "a desire to investigate fully the chosen topic and provide information-rich data" (Higginbottom, 2004, p. 14). Based on the research question, a minimum sample of 15 was thought to be appropriate. This number was based on the guiding question and the potential categories to which participants could be assigned. Categories determined for the study included participants from the lower, middle, and upper range of the age category as well as representation from various diagnosis settings.

Determination of sample size also can depend on analysis revealing a lack of new knowledge being identified. Thorne (2008) does not promote the idea of data saturation. Rather, she endorses an analytic process of probing data for outliers to identify predictable or rare but relevant findings that are not present. Probing for outliers is described as a method of moving beyond typical questions that one might ask when testing the data. Looking for new possibilities or potential topics not discussed will lead the researcher to probe for outliers that might have been lost in the data. This process requires analytical thinking that goes beyond the original findings. This method was used to determine if there was anything else to be known prior to ending data collection.

Recruitment began in April 2014 and the pilot interview was conducted in May 2014. The study interviews were conducted over a two-month period. Concurrent analysis helped the PI determine the point when no new information was being obtained; the potential for outliers was exhausted; and the basic categories of upper, middle, and lower ages and varied diagnosis settings were met. When this point was documented, interviewing was terminated.

Informed Consent and Blood Pressure Measurement

Each participant was provided a copy of the IRB-approved informed consent (Appendix D) at the time of the interview. After verbally reviewing the consent with the participant in a private location and obtaining written consent, basic demographic information was collected. Next, each participant consented and allowed his blood pressure to be measure using a hand-held sphygmomanometer, blood pressure cuff, and stethoscope. Blood pressure readings were shared with each participant except one. This participant consented to blood pressure monitoring, but the PI was unable to obtain an accurate reading due to the limited cuff size. A thigh-size cuff was obtained and used to obtain accurate readings during subsequent interviews.

All participants received an information sheet obtained from the American Heart Association website entitled, *If I have HBP, what can I do to take care of myself?,* and a $25.00 gift card when the interview was completed. Participants with elevated blood pressure were encouraged to seek medical attention and given a list of local clinics and medical resources. Additionally, the PI discussed the information sheet with hypertensive participants to encourage blood pressure management.

Demographic Information

Prior to data collection, each participant was asked to complete a short demographic questionnaire (Appendix E) that asked participants to record their age, marital status, education level, income level, and insurance status. Participants were asked to supply information about the clinical setting where they were diagnosed with HTN including the name of the facility, the title of the practitioner discussing the diagnosis with the participant, and whether they were given written information about HTN after their diagnosis. A final question asked participants if they were willing to participate in a follow-up interview if selected. Most were willing to participate

in a follow-up interview if selected. Six participants requested mailed copies of their interview transcript. Three participants requested the transcript to be emailed. The remaining participants were not interested in viewing their transcripts. All transcripts were mailed or emailed as requested with a cover letter requesting their feedback should any changes be indicated (Appendix G).

Data Collection

It is important for researchers to maintain an open mind during data collection and analysis. In interpretive description, the researcher seeks to generate knowledge inductively. Carefully noting and examining the ideas researchers bring to a study should be done to prevent these ideas from influencing what the researcher sees and hears (Thorne, 2008). For this study, the PI maintained a reflective journal of the personal and disciplinary influences she felt should be considered when analyzing the data (Thorne, 2013) (Appendix I). Prior to reviewing transcripts, research team members also were asked to note and examine their personal and disciplinary ideas regarding the study focus.

A pilot interview helped the PI to eliminate, develop, and organize questions to improve the quality of the data solicited. The interview guide (Appendix B) served as the data collection tool. A semi-structured interview process was used to promote conversation about the study topic.

Prior to the interview, participants were reminded of their voluntary participation. They also were informed that they could skip any question or stop the interview at any time. All interviews were audio recorded on two devices: the HD recorder application for iPad and a Sony digital recorder. The opening questions were, “Can you tell me about your experience of being diagnosed with high blood pressure?” and, “What led you to seek medical attention?” To

conclude the interview, participants were asked, “How do you think the experience could have been better for you?” and, “Is there anything else you would like to tell me about your experience of being diagnosed with high blood pressure?” Participants were thanked for their participation and given an AHA information sheet, a copy of the informed consent, and a $25 gift card.

Once the interview process was completed the participants returned to the food pantry to receive goods provided by the church. After each interviewee left the room, field notes were recorded immediately to capture the interview’s context, observations, emotional tone, rapport, and power dynamic. A sample from the field notes is provided in Appendix H.

Managing the Data

Thorne (2008) encouraged researcher engagement in the transcription process as attention to words, sounds, and silent moments can facilitate an intimate understanding of the data. For this reason, the PI transcribed the three initial interviews. To allow the PI to analyze the initial interview data prior to conducting more interviews, a transcriptionist—who signed a confidentiality agreement—was hired to transcribe the remaining 14 interviews. The PI checked all transcripts for accuracy by listening to the recording while reading the transcripts. Once a transcript was determined to be accurate, the initial analysis began.

During transcription, specific names identifying clinics or people interacting with the participant were altered to protect privacy. Initially, transcripts were sorted by a combination of date, location identifiers, and number of interviews. Transcripts were later coded with pseudonyms for referencing data during discussion. Confidentiality was maintained at all times.

Members of the research team who viewed transcripts completed a confidentiality form (Appendix C). Recordings were kept in a password protected computer file on the PI’s home

computer. After completion of analysis and reporting, all recordings were permanently deleted. Printed copies of transcripts, consent forms, and demographic information sheets are kept in a locked file at the PI's home office, accessible only by the PI. All informed consent statements and biographical sheets will be maintained at the University of Tennessee's College of Nursing in a locked file accessible by the dissertation chair for three years prior to destruction.

Data Analysis

The most essential element of a credible interpretive description study is the intensive process of analyzing the data to generate new constructions that are meaningful and relevant (Thorne, 2008). The inductive process of interpretive description analysis may be informed by formal analysis methods. One method often used to inspire the interpretive description analysis process is constant comparative analysis, which is generally associated with a grounded theory methodology. Constant comparative analysis combines explicit data coding with an analytical style for theory development (Glaser, 1965). This method is concerned with generating and plausibly suggesting properties and hypotheses about a general phenomenon. Tenets of the method such as comparing incidents and integrating categories and their properties were useful in the interpretive description analysis for this study.

The Initial Analysis

Interpretive description requires the researcher to see beyond the obvious questioning and testing what is observed in the data (Thorne, 2008). An experienced qualitative data analyst uses techniques and insight to collect and manage data while reducing inner reflexes—personality, educational background, and experience—that can introduce biases into the process. This method's initial analysis phases allowed the time needed for reflection. The initial analysis began with a broad sorting of the data from individual transcripts. Words and phrases that reflected

meaningful responses were underlined, circled, or highlighted. Because several interviews occurred at each recruitment event, it was not possible to transcribe and analyze interviews in preparation for the next interview. However, the PI was able to build a foundation from the first three interviews as they occurred at least a week apart. Initial data coding and constant comparative analysis were ongoing throughout data collection.

The initial analysis identified pieces of data that attracted attention or caused a reaction, creating an opportunity for questioning why these pieces demanded consideration (Thorne, 2008). This analysis became an act of contrasting the expected with the unexpected, which stimulated the senses. For each transcript, the PI engaged in confirming accurate recording of transcripts and immersion in the data while developing a sense of the whole piece.

Coding

Interpretive description requires a broad-based, generic coding process (Thorne, 2008). Broad-based coding allows groups to be established such as age categories or participants diagnosed in similar medical settings. Categories by age, diagnosis location, perception of HCPs, emotional response to diagnosis, and engagement in health behaviors were identified for further analysis to determine what relationships might be present. Generic identifiers were used to prevent assigning meaning too early and guiding the interpretation into false findings.

Descriptive coding followed the initial coding. The descriptive coding approach involves summarizing a passage of qualitative data using a word or short phrase that captures the basic meaning (Saldaña, 2013). This approach is appropriate for qualitative studies and is particularly useful for novice researchers. Descriptive coding can help the researcher answer general questions aligned with the interpretive description design: *What is being shared here?* and, *What*

does this mean within the scope of the study? Such questions were asked during the iterative process that included reading, listening, thinking, and writing (Thorne, 2008).

To remain close to the data, the PI performed all data coding by hand, without the help of a computer program or research assistant. Listening to the recordings and reading the transcripts helped place the participants' words in the context of their delivery.

Memos

The use of marginal memos involves categorizing text previously coded as potentially meaningful into categories using colored markers to represent thematic similarities (Thorne, 2008). This method is consistent with the analytic thought of interpretive description. Memos and short biographical sheets were completed for each participant during the analysis. As the individual analysis shifted into group analysis, the coded data were translated into categories with similar topics. Once it was determined that items fit into a category, a generic identifier was used to label the groups of meaningful text. The generic categories contained opposing topics—such as support and lack of support—to describe individual situations.

Analysis as Groups

As the analysis shifted from linking patterns and groupings in individual cases to those in the whole data set, levels of clarity began to emerge (Thorne, 2008). Keeping the mind strategically and constructively focused during the process was of utmost importance. The biographical sheets helped the researcher keep the data organized and allowed for inter-participant comparisons. With pages of data to compare, it was important for the PI to remain focused on the research questions while simultaneously noticing the themes that emerged.

The biographical sheets helped the PI achieve a deeper data analysis by allowing her to group participants into a variety of categories such as age, duration of condition, location of

diagnosis, and behavioral traits. Comparisons were made between the categories to determine such things as the likelihood of participants in the lower age range to engage in health promoting behaviors compared to those in the upper age range. Thorne (2008) stated, "stepping away from the data to ask yourself 'What am I seeing?' and 'Why am I seeing that?' forces" (p.158) acknowledgment of different possibilities based on the lens through which the data is viewed. This process, identified by Thorne (2008) as *confirming your bases*, includes the use of alternative perspectives. Using categories helped the PI step away from the data to view it from the nursing perspective and again from a social constructivist standpoint.

Testing Relationships

As patterns and relationships began to form, the PI asked, "What is missing?" and, "What else could be seen here to further test the data?" (Thorne, 2008, p.158). Miles and Huberman (1994) stated, "Any given finding usually has exceptions" (p.269). It would have been easy to explain or ignore the exceptions, or outliers, but the items that did not seem to fit helped test the basic findings.

Once it was determined that the research goal was achieved through the findings, one participant was asked to review them and—rather than confirming results—share anything he thought was missing. This participant reviewer evaluated the findings from two perspectives: first as a person living with HTN for the three years, and second as a Registered Nurse using his disciplinary lens. His feedback fulfilled a step called credibility checking. The study's rigor is enhanced by his validation of the analysis as accurate and conclusive.

Ethical Considerations

In all research, participants' privacy and confidentiality must be protected. In qualitative research, the profound experience of *being heard* is recognized as an opportunity for people to

share their personal experiences in a manner to which most are not accustomed (Thorne, 2008). Sensitivity to participants' needs for privacy and confidentiality was demonstrated by the study's informed consent document (Appendix D). Reassuring participants that their privacy would be maintained at all times was a priority of this study. In contrast, at no time were participants coerced or manipulated to participate or continue in this study against their wishes.

Privacy considerations for the research process and product were explained thoroughly to participants prior to their signing the informed consent document. Participants received instructions for the appropriate oversight committee about any concerns or possible violations. To maintain confidentiality of participants' stories, all interviews were conducted in a mutually agreed upon private location. Phone conversations with participants were conducted on a private line managed by the PI. The transcriptionist signed a confidentiality agreement prior to working with the recordings. Data were made accessible to dissertation committee members only after each had signed a confidentiality agreement. Private, individual emails were used for electronic transmission of data between dissertation committee members and the transcriptionist. Recordings were kept in a locked file cabinet and on a password protected iPad accessible only by the PI.

Maintaining Rigor

The steps taken to ensure a study's rigor and trustworthiness can influence its overall quality. A qualitative study's relevance and value ultimately should be determined by its rigor (Thomas & Pollio, 2002). This study's value is that it adds to the scientific knowledge about an understudied high-risk population in a way that has the potential to inform clinical practice. This study's relevancy is found in the information it provides for promoting improved outcomes for individuals diagnosed with HTN locally, nationally, and globally.

Techniques that add credibility to research include researcher credibility, analyst triangulation, and member checking (Patton, 2002). Thorne (2008) recommended the incorporation of "epistemological integrity, representative credibility, analytic logic, and interpretive authority" (p.102) to enhance the credibility of interpretive description. Building these measures into the design for this study helped to produce findings that accurately reflect participants' experiences. Other strategies that added rigor to this study, previously discussed in this chapter, included iterative readings, constant comparison, and journaling.

Researcher Credibility

Patton (2002) suggested four primary ways an investigator can affect a study: reactions to participants, changes in the investigator, predispositions of the investigator, and investigator incompetence. I addressed these potential problems by educating myself and relying on my expert committee members for oversight and direction. I conducted a pilot interview that the committee members reviewed prior to beginning the study. My understanding of the study topic and population helped me engage participants, increasing my awareness of potential responses thus facilitating control of my reactions. Epistemological integrity also was maintained by my role as the primary, single investigator engaging in the participant-interviewer relationship.

It is impossible to eliminate all bias from a study. Instead, effective qualitative research includes an accounting of all personal or disciplinary biases (Thorne, Kirkham, & MacDonald-Emes, 1997). In this study, reflective and reflexive journaling and field notes were used to capture, interpret, or counter perceptions and biases that could influence the analysis. In addition, all journal entries and field notes were reviewed during data collection and analysis.

Analyst Triangulation

The strategy involves having two or more people analyze the same qualitative data and comparing their findings (Patton, 2002). Although not all transcripts were analyzed by more than one person, two transcripts were reviewed by two of my four dissertation committee members. The committee chair, an expert in qualitative research, reviewed and commented on an additional transcript. Since I had previously reviewed this transcript and four others, her review provided a basis for confirming my previous analysis work.

The process of "engaging the critic" (Thorne, 2008, p.161) elicits external perspectives that allow the researcher to evaluate findings and account for differences in views. The dissertation committee chair and one other committee member reviewed and commented on the findings. Their familiarity with the population and previous research experience added a critical perspective to the results. Capitalizing on the knowledge of experienced qualitative and quantitative researchers added validity to this study's findings.

Member and Credibility Checking

Member checking involves asking some of the participants to comment on portions of the polished or semi-polished research products such as findings, themes, or descriptions (Creswell, 2014). This strategy is extremely important in transforming the data into accurate findings (Thorne, 2008). Taking the findings back to the participants not only allows the researcher to share what was learned, but also allows the participants to note aspects that do or do not reflect their experiences. While Thorne (2008) does not endorse traditional member checking for interpretive description research, she does recommend a modified version referred to as credibility checking (Thorne et al., 1997). To avoid the contradictions that come from asking a participant to comment on findings from the data they provided in a single interview, credibility

checking uses conceptualizations that represent the entire sample. The critical insights gained from participant perceptions about why the researcher's interpretation does not fit (credibility checking), rather than why it does fit (member checking) are extremely useful for challenging and refining theoretical linkages.

In this study, credibility checking was used to seek findings that might be missing from the analysis. The interpretive description approach is designed to include a disciplinary lens (Thorne, 2008); thus, a Black male – a nurse – meeting the study criteria reviewed the findings from this study. His review contributed to the confirmability of the results, specifically relating to nursing and/or healthcare practice. The use of credibility checking also added to the study's rigor.

Epistemological Integrity

Meleis (2012) defined epistemology as "a branch of philosophy that focuses on reflection on and investigations about the nature and foundation of knowledge" (p.26). The study's goal to develop knowledge was grounded within the perspectives discussed in Chapter One. The research question guiding the study was consistent with epistemology, which also facilitated the decisions about the research design.

In qualitative inquiry, researchers should demonstrate an appreciation for the epistemological position and respect those positions when making decisions (Thorne, 2008). From the basic assumptions about knowledge development to the methodological decisions, a study should follow a defensible line of reasoning. To produce credible findings from this study, the interpretation of data sources and the interpretive strategies used were consistent with the epistemology from which the research question was derived. This study focused on the knowledge developed or co-created between the participant and researcher. As participants

shared their experiences, the researcher inductively derived an interpretation that answered the research question. Semi-structured interviews stimulated the sharing of knowledge between the interviewer and interviewee. The interviewer used probing questions to learn more about the participants' stories and verify their shared experiences.

Representative Credibility

Representative credibility involves theoretical claims supported by analysis of study data (Thorne, 2008). This type of credibility assures that the theoretical claims purported are consistent with the phenomenon of focus and the representative sample studied. Generalizability or transferability of results for this sample representing a single gender and minority population may be limited to similar populations in the mid-south region of the U.S. However, findings may be generalizable to persons newly diagnosed with hypertension who have similar cultural health behavior habits. The clinical settings and circumstances surrounding where participants received their diagnosis were varied. In addition, participants' treatment plans, interventions, and quality of information provided at the time of diagnosis were inconsistent. These variations may limit generalizing these findings based on the clinical encounter at diagnosis.

Analytic Logic

Claims assuring the reader that an inductive reasoning process is used in a research study are not sufficient for credibility or replication of a study (Thorne, 2008). An audit trail demonstrating the reasoning pathway was a sufficient method to ensure the reader of a credible process to explore the data. The process of this study is well documented and provides an accurate reporting of the findings.

Interpretive Authority

Recognizing that knowledge is perspectival, it is important to have assurances that the researcher's interpretations are free of bias and therefore reveal an external truth (Thorne, 2008). For this study, the process of reflective journaling and recording field notes and then referencing this information during the data analysis was used to prevent introducing bias or preconceptions into the findings. In addition, credibility checking confirmed PI interpretations and probing interview questions verified the accuracy of participants' stories. Moreover, using the participants' actual words further supported the validity of the reporting process.

Threats to Validity

The PI sought to minimize threats to study validity by immersing herself in the data through transcribing some interviews and checking and rechecking all transcripts. In addition, to maintain study integrity, data were evaluated meticulously and systematically using a broad initial coding strategy and a memo technique for underlining, circling, and highlighting thematic categories.

Thorne (2008) warned novice and unsuspecting researchers about the potential research traps of premature closure, over-determination of pattern, misinterpretation of findings, and over-inscription of self. Taking a fresh look at the data—by asking a variety of questions to explore a wide range of possibilities—helped me decrease validity threats during the data analysis. These questions included, "*What is being shared?", "How does this fit with the data?", and "What underlying meaning is the participant trying to convey?".*

Conclusion

The generic nature of the interpretive descriptive approach can be both a challenge and an asset to a novice researcher. On one hand, its lack of prescribed methods leaves novices to

question their research choices. On the other hand, it gives researchers the flexibility to explore the data in many ways in order to answer the research question(s). As this study's data were questioned using varied views, including the nursing disciplinary perspective, many possibilities emerged. Using the interpretive description approach allowed the PI to reflect on the clinical experiences described by Black men, aged 18 to 44, who had a HTN diagnosis for fewer than three years. Participants' memories about these diagnostic encounters were found to be credible and coherent. Evaluation of the findings identified from participants' perceptions of the clinical diagnosis experience, while keeping in mind their subsequent health behaviors, brought a new understanding of the data.

Use of the flexible approach of interpretive description facilitated the creative process of analytical thinking. Because it is impossible to separate a researcher from his or her discipline and personal history, the potential for researcher bias was acknowledged and accounted for through such strategies as reflective journaling and field notes. Using the additional element of the disciplinary lens also accounted for and made use of the investigator's disciplinary knowledge and the potential bias that could arise from it. Such efforts added validity to the findings.

In this study, credibility checking and obtaining external perspectives on the findings further enhanced their validity. Use of the biographical sheets and coded data sets allowed for inter-participant comparisons. These comparisons of the participant's age, time since diagnosis, or location of diagnosis demonstrated commonalities in how they responded to their diagnosis and the steps taken to manage the condition.

Chapter Four: Findings

Introduction

The purpose of this study was to explore the perceptions Black men have about their clinical encounter when diagnosed with HTN and to interpret their life experiences after diagnosis. This chapter presents the research findings beginning with participant demographics. Next, the contextual grounds of the participant stories, and the symptoms and events leading to participants seeking medical care are discussed. The findings are divided into two parts. First, an examination of how participants responded to their diagnostic healthcare encounter and how they were trying to manage their HBP is presented. Second, the thematic analysis is presented, which illuminates why management generally was not adequate and the barriers to effective management (denial, fear, and frustration).

Reporting these elements—participants' perceptions of the clinical interaction, responses to the diagnosis, and management influences, experiences, and strategies—is consistent with the disciplinary allegiance recommended by Thorne. The nursing perspective encourages the researcher to identify what influences participants when making choices that promote effective HBP management and how these choices align with evidence-based AHA standards: consuming a healthy diet, participating in exercise, practicing weight management, avoiding tobacco products, limiting alcohol consumption and taking medications.

Participant Demographics

Demographic data were collected to evaluate the participants' education, income, marital status, and insurance status in relation to health behaviors affecting blood pressure management. Participants' blood pressures were taken and recorded to provide health information. However,

an elevated blood pressure reading prompted a conversation about actions that can promote effective management of their condition. Additional demographic information collected prior to interviews was used to compare of groups based on lower, middle, and upper age categories; length of time living with the diagnosis; the type of facility where diagnosed; clinicians and others who discussed HTN management with the participant; and written information provided at time of diagnosis. Table 4.1 provides data and socioeconomic characteristics for all participants.

Contextual Influences

Each participant had a unique story to tell. Reflecting on how participants perceived and experienced life provided a contextual ground for understanding their individual stories. How they experienced life and health affected their adaptability and life choices. Experiences in childhood and early adulthood also influenced current behaviors and life choices.

Childhood and Early Adulthood Events

As one participant described his childhood and early adulthood, it became evident how his life experiences affected his health. Pseudonyms are used to protect participants' privacy. Ben is a 44-year-old Black male with an alcohol abuse problem who was diagnosed with HTN almost three years ago. He was sought medical attention after his mother and wife "pressured" him to go to the doctor. While aware that HBP runs in his family, he was unconcerned because his life is "way better than where I came [from]." His lack of concern about his health stems from his past life experiences.

> I've learned at an early age not to even really care whether I'm here or not. I welcomed it [death], you know what I'm saying, it's got to be way better than what it is on earth right, you know, so I welcome it. I'm not rushing it, but I'm not scared of it either, so it's like, you know, however the ball roll, I roll with it.

Table 4.1 Demographic Characteristics of Participants (n=17)

Characteristic	*n*	*%*
Participants Blood Pressure at time of interview (mm Hg)		
140/90 or above	9	53%
120/80 to 139/89	3	18%
Under 120/80	4	23%
No BP reading obtained (missing data)	1	6%
Age at time of interview (years)		
18–24	1	6%
25–34	5	29%
35–44	11	65%
Marital status at time of interview		
Single, never married	14	82%
Married or living with significant other	2	12%
Divorced, separated or widowed	1	6%
Highest education level completed		
Less than 12th grade	6	35%
High school or GED	8	47%
Some college	1	6%
College graduate	1	6%
Graduate school	1	6%
Annual Household income		
$0–$9,999	12	70%
$10,000–$14,999	3	18%
$15,000–$24,999	1	6%
25,000-34,999	0	0%
35,000-45,000	0	0%
Over 45,000	1	6%
Insurance status at time of interview		
Uninsured	11	65%
Partial, inadequate insurance	0	0%
Disability or government sponsored	4	23%
Private insurance	0	0%
Insured by employer	2	12%
How long diagnosed with HBP		
3 to 6 months	4	23%
7 to 12 months	3	18%
13 to 24 months	4	23%
25 to 36 months	6	36%
Where diagnosed with HBP		
Clinic	6	35%
Hospital	7	41%
Correctional Facility	3	18%
Blood Bank	1	6%
Discussed Diagnosis with		
Doctor	17	100%
Nurse	7	41%
Family member	4	23%
Friend	3	18%
Received written information about HBP		
Yes	11	65%
No	6	35%

Ben's story began with a father "who was not a father." Because of his hatred for his father, it was difficult for him to be compared to his father. He believed that, for the first 30 years of his life, he was trying to live his life like his father, not caring "whether I lived or died." Ben explained his belief that it is common for many Black men to have fathers whom "never stood to be men." As a result, "by the time you actually get to 21 or 22 years old, you done did everything there is to be done, which makes them not care." Drinking and drugs were things he used to excess. His stepfather turned him around. He says, "if it wadn't for him, I'd already be dead and gone." Even today, getting a message from his father can send him over the edge. Once while traveling with his sister, his mother called to tell him a few things his daddy had said, which in turn, "stressed me [out so much] that my blood pressure shot out the roof and I couldn't drive." At age 44, Ben's life remains influenced by the lack of a relationship with his father. The stress from his past affects his health as well as his attitude toward health promoting behaviors. Although he says he is better now, he also acknowledges the difficulty of managing his blood pressure when stressors, such as dealing with his father, arise.

Being Incarcerated

Three of the 17 participants shared their experiences of being diagnosed with HTN while incarcerated. Dave expressed how "stressed" he was. To add to his concerns, a close friend who had been encouraging him to seek medical care for his dizzy spells had a tragic accident. The friend "got dizzy. He hit his head on the side of a table, his temple on the side of the table, and he never did wake, wake back up anymore." This was a "scary moment" for the newly diagnosed Dave who had been having similar symptoms. Incarceration is not a traditional risk factor for HBP, but as this participant shared, it can be very stressful. Imprisonment is a remarkably common event for Black men who have low education levels and reside in poor neighborhoods

(Lee, Wildeman, Wang, Matusko, & Jackson, 2014). It is reported that 60% to 70% of Black men with a less than a high school education may face imprisonment by their early 30s. Imprisonment can promote stress, which may lead to health problems such as HBP. Stressed and scared, Dave became serious about seeking medical care for his dizzy spells where he was diagnosed with HTN.

Loss and Suffering

Many of the participants shared their experience of seeing family members debilitated from the long-term effects of HBP. The loss of parents, grandparents, a wife, sisters, brothers, aunts, uncles, and cousins from strokes, heart attacks, renal failure, and diabetes remained fresh in their minds. Lars tells about his father's health as a catalyst for him to learn more about his own health.

> My, uh, my father has had two bysurgeries, bypass. He had a double bypass and he takes a lot of medicine and with him, with the books and pamphlets that he brought home he had high blood pressure and all that so, you know, that was what led me to get a little closer to it.

When Lars went to the doctor, his blood pressure was so elevated that the medical staff began emergency procedures fearing he would have a stroke.

Harry lost his first wife to renal failure. He found out about his HBP while she was in dialysis. During her hospitalization, he tried to learn more about his own health at a time when stress and worry were constants in his life. Others told stories of loss such as "My sister, my oldest, she died of high blood pressure. My momma died "cause she had sugar." Another participant shared, "one of my aunties, she had high blood pressure and she was in chemo at the same time so, you know, but the other one died of just straight high blood pressure." Jay, age 31,

said his two cousins had diabetes since their teen years and the he understands that HBP increases his risk of developing diabetes.

The illnesses and deaths of loved ones shaped many participants' perspectives about being diagnosed and living with HTN and prompted some to seek medical attention. While sharing loved ones' stories, many participants acknowledged the seriousness of HBP and expressed concern about being the next person in the family to have to deal with it.

Knowledge of Family History

In view of their family history, many participants believed that they also would have HBP at some point in their lives. With this perspective, learning they had HBP often was not a surprise. However, even with this knowledge, the response often was to deny the diagnosis by contending the doctor had made a mistake. Others said, "[I] did not know that I had blood pressure." One participant "thought it was a cold." Despite expecting to have HBP, many participants were not ready to make lifestyle changes or comply with a medication regimen. The emotional responses to their HTN diagnosis included being fearful, scared, depressed, stressed, shocked, and frightened. Pat summed it up stating; "Life is a lot better without having high blood pressure." While having a family history of HBP may have been intellectually suggestive to participants they could get HBP, in the actual diagnostic circumstance, the men's emotional reactions were pronounced and dysphoric.

Diagnosis

Participants shared a variety of symptoms that prompted them to seek medical care prior to receiving their HBP diagnosis. For some it was a serious event such as a heart attack or stroke. Others reported headaches, dizziness, blurred vision, nausea, swelling or numbness of hands and

feet, or frequent nosebleeds. A few sought medical care for other illnesses, accidents, or even stress.

Seeking Medical Attention

Only one participant, Lars, sought medical attention because he was concerned about his blood pressure. When his father had double bypass surgery, the literature he brought home led Lars to recognize his headaches might be related to HBP. His clinical experience included HCPs that were "nonchalant" until the doctor measured his blood pressure. The reading was so high that the doctor told him he was "threatening a stroke" and instructed personnel to call an ambulance. Because the nurse initially taking his blood pressure did not react to his extremely high blood pressure measurement until the doctor alerted the healthcare team, Lars now tests all health professionals to see if they are educated about HBP. Since Lars is now familiar with the symptoms he experiences when his blood pressure is elevated, he does not wish to deal with a HCP who does not understand HBP. Fortunately, I earned his respect when, after an initial reading of 180/100 mm Hg, I measured his pressure again and evaluated him for symptoms prior to beginning the interview.

The Clinical Encounter

Some participants went to the doctor for dizziness, blurred vision, nosebleeds, nausea, and various accidents. Most indicated they were treated well and felt respected by HCPs. One participant stated, "[I] knew they was trying to help me." A participant who was incarcerated at the time of diagnosis said, "They, uh, helped and talked to me, explained a little bit about it (HBP) then they gave me a little pink pill." Quint may have had negative experiences in the past, as his response to the inquiry of how the HCP treated him was "They wasn't hollering at me or nothing. They was just telling me about my health."

Being informed. Several participants did not receive the information they needed or felt the information they received was not presented well. Greg said of his physician's nurse, "She was ok. She, you know, she didn't explain everything cause she probably didn't know." During his encounter with the doctor, he began feeling worse as he was told his blood pressure was so high he could have a stroke or heart attack. His comments about the doctor were:

> They treated me fine, you know, they, they was real professional about it, you know, and they just didn't explain too much about it, you know, to make me feel a little better. They just gave me medicine and told me 'take this as you know we prescribed it.'

Being allowed to ask questions. Greg reported that when he tried to ask the doctor about his diagnosis, the "doctor went on out the door." He continued by saying,

> I really wanted to know cause, you know, I never, you know, I know high blood pressure runs in our family and I knew it's not a good thing. And since then, since I was told last year, I still ain't found out too much about it.

A friend referred one participant to his own trusted, personal physician so he could get information about HBP management. The participant, who was anxious to learn more, and had an appointment scheduled soon after the interview.

Odes refrained from asking his doctor questions because he believed there was a justifiable explanation for his HBP. While others indicated they had the opportunity to ask questions, some passed on the opportunity. Isaiah said, "I'm sure she did, um, and again, I'm the type of guy who probably did not have very many questions." Instead, Isaiah sought answers on the Internet. Participants may have declined to ask questions because they wanted to escape the conversation or did not know what to ask at the time.

Understanding. Others shared that they were "told a little bit." Many were instructed "not to worry too much" and to "take it easy." Some interpreted the take it easy remark to mean they should not work or should work less. Harry shared his perception of the doctor's instructions in the following:

> (The doctor) let me know how to take it easy and stuff like that, you know, see cause I was always working. And then when I, you know, when I finally went to the doctor and found out that I had it, so I just still had to work. I couldn't stop cause then my wife she was on dialysis.

From the interview data, it was clear that the clinical experience, while it may have been pleasant, was not educational or motivational. The HCPs did not provide helpful information or validate their patient's understanding, as these men continue to have many unanswered questions about their diagnosis. The only influence found between the clinical experience and compliance was in the confirmation that they now are among other family members with HBP. Jay clearly stated how the clinical experience influenced his choices.

> Being informed of my situation has helped me... just being aware ... that's the best thing someone can do for you. Everything else you have to kind of like do on your own... if I would had of known at the beginning... if I would have took it as serious, then my pressure would probably be where it's supposed to be now.

Perceptions of Their Interactions with Providers

There were positive comments about the healthcare personnel encountered regardless of the clinical setting. Ben was diagnosed at the doctor's office. When ask how he was treated by the HCP, he replied "Pretty nice. They talked to me, they explained to me what was going on with my body." A hospital admission resulted in Ed's HTN diagnosis. His remarked that he was

treated “real good” and he felt respected by the clinicians. Pat’s diagnosis came while he was incarcerated:

> They treated me pretty good. They were professional with their services or whatever. If you ask me, they did everything they could, you know, to possibly like help with the situation. They alerted me on the seriousness of hypertension and they really showed true concern.

Whether the examination and subsequent diagnosis took place in a clinic, hospital, jail, or other organization, participants’ remarks about the personnel were very positive. Healthcare personnel were viewed as professional, nice, polite, and caring.

However, when specifically questioned about the instructions they received, a different picture emerged. The instructional portion of the conversation regarding living with HTN did not always receive high accolades. Frank felt the clinicians were making fun of him,

> They were more joking and laughing and really was talking about “You overweight. You need to do this. You need to do that,” but telling me, come to me with paperwork and telling me “you know that you can walk. You can do whatever you want.” Feeling uncomfortable, they can talk to me one on one, not in front of your nurse and making jokes.

Other participants did not believe they received adequate information and some mistrusted the doctor’s diagnosis or recommendation. Greg was surprised that the nurse could not explain what was going on with his blood pressure, saying, she “didn’t explain everything cause she probably didn’t know.” Similarly, Lars said the clinician was “nonchalant” until the doctor took charge, alerting him and the staff that Lars was “threatening a stroke.” Dave thought the doctor “probably made a mistake.” Greg and Frank stated they were changing doctors, while

others were seeking a HCP to help them manage their condition. The patient-clinician relationship is an important element of HBP management. Trusting that the information provided by the HCP is accurate and complete can affect whether a patient adheres to a treatment plan.

Choices Regarding the Clinical Treatment Plan

The participants' stories showed a lack of full engagement in an AHA-approved treatment plan. Failure to follow the doctor recommended treatment plan and receive needed follow-up care results in unsuccessful HTN management, which can cause frustration for patients. The AHA approved treatment plan typically includes a healthy diet, physical activity, weight management, smoking cessation, limiting alcohol, and in many cases, medication adherence. While participants indicated they followed or tried to follow some of the guidelines, most did not follow all of the guidelines. Choosing to follow only selected guidelines may provide participants some control over their condition. However, experiencing the extreme blood pressure elevations associated with unmanaged HBP increases health risks.

Problems Related to Taking Medication

To Take or Not to Take Medications

Most participants who chose to take medication had experienced a major health event and did so in an effort to avoid disability or death. Andy who had experienced a stroke stated "I started taking my medicine now. I make sure [to take the medications]". Ed, who had a light stroke, stated much the same declaring, "Yes, ma'am, I take it every morning", when asked if he took his prescribed medication.

Participants who chose not to take prescribed medication explained their decision by citing forgetfulness, difficulty swallowing pills, not liking how the medication made them feel,

and a dislike for taking medicines. When asked if he was taking his medication, Isaiah shared his struggle stating,

> Yes, that's supposed to be something that I do, obviously, and I do not do it. I'm very inconsistent with my medication, ah, my wife gets on me all the time about that and, ah, so I've got to do better with that. I'll probably take it out of seven days a week, I'll probably average three or four days a week. I just, I either forget or it just doesn't seem important in the scheme of, in the grand scheme of things.

Curtis stated, "It [the medication] just made me feel horrible, you know, so I quit taking 'em". While, other participants equated taking medication to being weak or unable to control their health such as Jay who stated, "I don't want to be seen as like I need it [medication] or something".

Many of the participants were prescribed medication as a part of their treatment plan. Some adhered to their medication regimen with the help of reminders from family members. Frank, 23, used his smartphone to remind him to take his medication. Others, however, reported running out of pills and having difficulty getting a refill due to a lack financial resources or insurance coverage. In one case, the clinic would not call in a refill because they could not locate the man's records. Such difficulties seemed to contribute to participants' avoidance or denial of the seriousness of HBP.

Most of the men were provided a prescription and instructed to begin a medication regimen to treat their condition. Approximately six participants stopped taking antihypertensive medications because of side effects such as nausea, feeling weak, or just not liking how they felt on the medication. Participants were asked about various side effects including impotence, but most denied having this problem. Ed acknowledged his medication caused him to be impotent

but continued to take it due to the seriousness of his condition. Ed was encouraged to learn that there are other medication choices to avoid this side effect and said he plans to contact his physician. He had never discussed the impotence problem with his doctor.

A few participants take their medication only when they "feel it coming on." Finally, several participants simply did not like to take pills or any medicine believing they could manage their blood pressure on their own. Mack refused medication because he does not "really appeal to pills." His plan is to do things his way not "because someone else said so."

Overall, the only consistency found in medication adherence was that those making the effort to take prescribed medications had experienced a major event such as a heart attack, stroke, blood clots, or an extremely elevated blood pressure requiring emergency medical attention. While most failed to adhere to the physician recommended medication treatment, the lack of adherence may be attributed to the lack of understanding specifically regarding the seriousness and need for lifetime HTN management. Because elevated blood pressure often does not produce symptoms, participants may have a false sense of security and believe they no longer have to follow the treatment plan or monitor their condition.

Communication between patients and healthcare providers is critical for encouraging patients to take their medication. Quint, whose blood pressure was elevated at the time of the interview, said the following about his decision not to take his medicine,

> Yeah, I asked her [the doctor] was it nine times out of ten what I need to do and should I take it or what? She said if you don't feel like you need to take it, don't take it, so I just didn't. Far as mine, I don't like taking medicine anyway so I don't try to take no, don't take no medicine.

He also shared that he was told,

> If you go up, either take some lemon or drink some vinegar, that's all they ever told me. And when I feel like, I feel like it's going up, I go to the store and buy me a yellow lemon or bring a lemon in and bite the lemon, eat the lemon, then it's better.

No literature was found to support these practices. This comment also may suggest that the participant was having difficulty remembering the instruction he had received from the HCP regarding his blood pressure. Several participants mentioned the HCP and their mother telling them to drink plenty of water, a practice not included in AHA HBP management recommendations. Because family members and friends clearly share health information–whether it be evidence based or folk remedies–with each other, when HCPs provide accurate HTN management information, it may benefit more people beyond the patient who receives it.

Lifestyle Behaviors

In response to being diagnosed with HTN, the participants shared the types of sacrifices they made to decrease their blood pressure. Physicians' recommendations were similar to their mothers' instructions about managing HBP. The most common recommendations were to "drink plenty of water and try to stop eating salty foods" and "just drink plenty of water and take the pills on time." Patients often did not recall that physicians' explanations included the AHA (2013b) recommendations to consume a healthy diet, engage in physical daily activity, maintain a healthy weight, stop smoking and limit alcohol consumption. This may be because some of the men had been diagnosed up to three years prior to the interview and were unable to recall the details of the interaction. Another explanation could be that the HCP did not go over all evidence-based recommendations as they were contained in the written material that may have been provided at diagnosis.

Eating and Cultural Influences

Most of the participants reported their efforts to "back off the pork and fat." Harry thought he "was catching HBP" because of his diet. At the time of his diagnosis, he was eating "a little greens and, you know, beans, and neck bones. And then I eat pork too, you know. A little pork chops, you know how the Blacks' food be, you know, soul food." Isaiah had similar diet since he grew up in "Southern Mississippi… where, you know, lots of pork and those are the things that were just staples in our diet. You know, even when you're making collard greens you make them with ham hocks and lard." All men were aware of the need to avoid fatty foods. However, Mack questioned the effectiveness of dietary changes. His said his grandparents are in their late 90s and have always consumed "hog jowl, chittlins, it's just fat, fat, fat." In comparison, he stated,

> The average man is trying to diet, he's killing himself trying to diet, but he's not living past 54 or 55 you know. So, I mean, just why even bother. I would just like to live a happy, healthy life.

This opinion was the exception, however, as the rest of participants shared a desire to live a healthy life. Many participants justified their decision to continue to eat fatty pork and other fatty foods by doing so in moderation. Some also believed it was acceptable to consume pork as long as they also ate "healthy food" such as "string beans." Clearly, these men need more education about healthy food choices. As I listened to their stories and descriptions of their diets, the nurse in me wanted to interject information during the interview about the high sodium content of the luncheon meats they consume as well as other food choices they believed were healthy. However, this discussion was delayed until after the interview to prevent influencing the participants' stories.

Most participants mentioned the need to reduce the sodium in their diets including Curtis, age 27. Curtis who learned about his HBP approximately two and one half years ago in the emergency room, said,

> The doctor had told me that I need to slow down. He asked me do I eat a lot of salt and stuff like that. And he said do I eat a lot of, uh, grease, you know, all that type of stuff. And I was like, ah, I eat, I eat food, you know, I eat food so I don't know how much salt I be eating, you know. But I love sunflower seeds, though. I used to eat 'em all the time.

Curtis, a thin young man, did not express concern about weight management. Therefore, it might be hard for him to comprehend the need to examine the nutritional facts of the food he eats. His question about how much salt is too much is a valid question. However, he does indicate that he has stopped eating salty sunflower seeds. From the nursing perspective, his interview raises concerns about the information being provided to newly diagnosed HTN patients. The high sodium content in canned and processed foods, such as luncheon meat, is important information that, judging from this research, has not been a priority.

Only a few participants clearly understood the dietary requirements for managing HBP and how to incorporate them into their daily lives. Dave, who was diagnosed while incarcerated, understood his dietary restrictions. He shared that the diagnosing doctor often joined him for lunch and walks during his incarceration. This personal interest in his health served as motivation for him to follow his treatment regimen. I did not anticipate that participants would receive better instruction and support during incarceration. However, the structured environment and ongoing reinforcement Dave received in prison promoted consistency in the management of his HTN.

Weight Management

Approximately half of the participants stated they were overweight. The participants who expressed the need to employ weight loss strategies generally followed this statement with a reason why exercise was difficult or not a priority for them. Many lost weight right after their diagnosis, but had since gained it back. Throughout the transcripts, stress was the main reason participants cited for being overweight. Ben acknowledged that his weight was dependent "on what's going on in my life. If I get stressed out, it will, it will, I tend to eat cause I can't drink like I used to." Isaiah said that he "dropped all this weight, but then, you know, life happens and then I stopped, and I gained it back."

Physical Activity

Participants who exercised generally had an established walking routine. Engaging in this type of exercise during a Memphis summer brought on conversation regarding the area's extreme temperatures and humidity. Most who walked stated they had to limit their outdoor activities in the warmer months.

Participants who enjoyed sports tried to play football or basketball whenever possible. Jay said he plays football on the weekends when he is not working. Others were limited by such conditions as having a "bullet in my back and rod in my leg" or "back pain." Many participants had other health concerns including diabetes, physical injuries and impairments, or a past stroke or heart attack. The additional burden of HTN management may raise their awareness of what the future holds for lifelong management of their health.

Smoking

A few of the participants were non-smokers prior to their diagnosis, thus escaping the need to quit smoking. Others, like Ed, had "backed up off the cigarettes," while Greg was "trying

to quit smoking." Andy switched from cigarettes to cigars only to be told by his doctor that cigars were worse than cigarettes. Participants reported struggling to quit smoking. Andy admitted, "I really do smoke a lot of cigarettes and that's why I needs to stop." Participants' view that "cutting back" on cigarettes was adequate to address their HTN indicated a lack understanding about the effect of tobacco products on blood pressure.

Alcohol Consumption

In their guide for HBP prevention, the AHA (2014) recommends that men drink no more than two drinks per day. Some of the men indicated they were trying to limit their alcohol consumption since being diagnosed. A few shared that they were "alcoholics", giving them another reason to avoid alcohol consumption. Ben has an alcohol problem and stated, "I stopped drinking heavy alcohol all together. I tend to get me a beer or two a day." He suggested that he could control his alcohol consumption as long as he stayed away from friends and family who consume alcohol.

Four participants were non-drinkers, while others were occasional drinkers. A few participants reported being told by healthcare professionals to quit drinking. Mack said, "They actually said that I, you know, really need to quit drinking." When asked if he did so, he responded,

> No, I didn't … but at the same time, I did, you know, think about things as far as consumption level or things like that. You know, change some things up, you know, things I don't like, I might like now, you know. Maybe a wine for dinner or something like that, and I don't even like it, but, you know, just willing to give myself an opportunity to live.

Like many participants, Mack was given instructions by his healthcare professional, but believed he could manage his blood pressure without completely following the doctor's recommendations. His grandmother, who is 96, and his grandfather, who is "a hundred and something," eat "hog jowl, chittlings," and other fatty foods. He also believes that "the average man doesn't live past 54 or 55 without some heart problems." For these reasons, he does not think that what he eats is an important factor for health management.

Social and cultural pressures to consume alcohol in certain situations may play a role in how these men address the need to limit alcohol consumption. Ben avoids situations and gatherings that encourage heavy alcohol consumption. In contrast, Mack will drink wine, which he does not like, instead of hard liquor, in order to be a part of his social group. Both men expressed the importance of controlling their alcohol consumption and reported exhibiting some level of control over this factor in their daily lives.

Influences on Behaviors

Life choices and behaviors can be influenced by many social and environmental factors. As these men shared their stories, several pertinent influences became evident: family, heritage spiritual beliefs, and the need for knowledge. Learning about these influences gave the PI insight into how they affected participants' post-diagnosis behaviors.

Family

Participants' mothers were the most common influence linked to positive lifestyle behaviors that complied with some of the AHA recommendations for managing HBP. Most commonly, the mother positively influenced medication adherence and dietary changes. In addition, children—such as grown children who called to remind their dad to take his medication—played an important role. In some cases, men cited their children as the reason they

were willing to share their stories and learn more about dealing with HBP. Regardless of age, the men expressed the importance of being present for their children. Participants also wanted to learn more about HBP in order to teach their children about the disease and help them to live healthy, active lives. Children were viewed as motivators that encouraged health promoting behaviors and seeking knowledge about HBP management to share with future generations.

Heritage

Most of the participants were aware that HBP was hereditary for them. Curtis discussed members of his family who had HBP. As he spoke, he realized that, "everybody damn near got high blood pressure." He admitted he had not thought about the topic before the interview and displayed a look of surprise as he acknowledged how HBP has affected his family. His response was a common one among participants. The interview process seemed to serve as a wakeup call alerting participants about the seriousness of HTN. Others, like Nolan, knew that HBP "… runs through my family," but admitted, "I don't even know how I even got it or how it happened, I just know it's happened."

Much can be said for the family influences, yet without understanding what it means to have a condition such as HBP "run through" a family and what the implications are for family members, this knowledge may be useless. As previously mentioned, the opportunity to educate or re-educate families about the condition and to provide accurate and current information is evident. There are many knowledge gaps in the messages carried down through generations of family members with HTN.

Spiritual Beliefs

Many participants relied on God as the protector of their health. Even though his blood pressure was 180/100 mm Hg at the time of the interview, Lars felt he was not "having a

problem right now. To me, I am just as healthy as the next person." He believed "the Lord, He has enabled me to do the things that others do so I don't have no defects."

Odes said, "I just pray about it, all I can do is pray about it." Another participant said, "I'm just gonna pray to God and ask God to lead me the way and that's all that I have to do." Others shared similar comments about their reliance on God to provide them comfort and support for managing their blood pressure. Quint probably mirrored the feelings of all participants when he said, "Wish I never had it. Wish God lets me have, what it's called, benefit of good health." These statements could be interpreted as a decision to ask God deal with the HBP instead of adopting healthy behaviors to manage the condition. With 70% of the participants having an annual income of less than $10,000, their reliance on others and faith-based organizations is reflected in their beliefs. Since the participants were at the church to take advantage of its food pantry, their religious beliefs are not surprising. However, participation in a faith-sponsored event does not constitute religious affiliation or beliefs.

Need to Know More about HBP

Most participants seemed to realize that HBP is a serious condition. As one participant stated, "I know high blood pressure runs in our family and I knew it's not a good thing." Some wished they knew more about HBP, while others wish they had known about it earlier, or had taken it more seriously. Curtis learned his blood pressure was elevated at the age of 17 while attending a health fair. The nurse at the fair instructed him to see his doctor. He received information about HBP but it ended up in the back of his car and was later thrown away. In his interview he stated, "I really should have been reading up on it and all that." Ten years later his desire to learn more was a result of a recent emergency room visit where he was diagnosed with HTN.

Many participants believed that drinking plenty of water could help them to manage their blood pressure. Most thought that reducing their cigarette smoking could eliminate the problem. Harry believed that he would not have the condition now if he had gotten treatment sooner. No participants mentioned understanding the possible effects of unmanaged HTN, nor did they discuss the lifelong need to manage the condition. From a nursing perspective, these beliefs support the thematic conclusion discussed later in this chapter.

Support from Others

Although some made comments such as "it's just, it's something that I've kind of got to do myself," or "it's up to me." All participants spoke of family or friends who supported them. Some reminded them to put the saltshaker down or to take their meds. Regardless of their role, it was evident that those who provided support were important to these men. Support from others can serve as reminders, motivators, or provide information. In some cases, the support person is learning along with the participant while seeking answers to their own new diagnoses. The quality of the support person's knowledge can be critical in promoting health behaviors that have a positive effect on blood pressure management. However, with support of others and faith in God, participants acknowledged that their choices are critical to improving their condition.

Parental Support

Mack did not want to discuss potential health support from his family. He stated "we are gonna skip the family part because they only have a one-track mind." Further questioning revealed his family conflicts as the youngest child with four older sisters. He added, "Everybody was hard-headed except my mother."

Other participants spoke mainly of learning about HTN from their mothers. Generally, the participants' mothers checked on them, reminded them to take their medications, and

promoted eating healthy. Several participants' mothers had said, "You better get your blood pressure checked." Others identified their mother as a motivator who urged them to manage their blood pressure "because it would get me sick, sicker, you know." Ben stated, "The only reason I'm really not [leaving] here cause my mama's here, but once my mama leave here, I couldn't even tell you what I'd do." Mothers play an important role in these men's lives.

Some mentioned their father but often in the context of poor health. Some participants' fathers had died from HTN related illnesses. Lars spoke about his father, who was very ill because of cardiovascular disease,

> "He had a double bypass and he takes a lot of medicine and with him, with the books and pamphlets that he brought home he had high blood pressure and all that so, you know, that was what led me to get a little closer to it".

Family members' negative health events prompted several participants prompting to seek medical care. While initially Mack did not want to acknowledge family influence, further discussion revealed that his parents and older sister have HTN. Although he denied their influence in his life, his knowledge of their condition—and potentially hearing about their efforts to manage it—could affect his choices now that he is aware of his HTN. Others participants reported listening to their mothers, whether they wanted to or not. A few participants indicated their faith influenced them more in managing their condition than had any family member. Several of the men who professed faith-based support had lost their mother due to HTN related illness or cancer. Loss of their mother may have promoted these men to rely on other sources of comfort and support to help them deal with their life struggles.

Children

Each man had softness in his voice or expressions when speaking of his children. Participants expressed a desire to be healthy and enjoy life with children and grandchildren. Andy shared his concerns by saying, "I worries about my kids a lot and cleaning up and, you know, stressing, and stuff like that." Although some participants receive emotional support from their children, they may also be a source of stress, as they did not want their children to see them in failing health or worry that they might die. Andy went on to say,

> I want to be here to be with the kids and my grandkids and share their life. I don't want to be stuck in the bed or, you know what I'm saying, everybody wondering what's wrong, you know, what's going to happen to me. I don't want them to feel sorry or nothing like that for me. I don't want nothing like that to happen.

This passage shows that children can be a source of motivation. Yet, fulfilling the desire to be healthy to spend time with children and grandchildren requires men with HBP to make the effort needed to manage their condition.

Significant Other

Only a few participants mentioned having a wife or an ex-wife in their lives since diagnosis. Frank's significant other contacted him the day of study recruitment asking him to participate in this study. He came to the church because she informed him about the study and he hoped to learn more about HBP by participating. Many of the women at the recruiting site demonstrated greater interest in the study than did the men. The women asked questions and shared their knowledge of the *silent killer*.

While a few participants were prompted by their wife or ex-wife to seek medical attention, generally the men did not mention a wife, ex-wife, or significant other as they talked of

living with HTN. This was not surprising as14 of the 17 participants were single and had never married.

Friends

Mack says he has "associates" who "motivate me actually more than my family does." Dave named several friends with a big smile that quickly faded when he mentions a particular female friend. His concern was evident as he said,

> They said her blood pressure was up so bad to where she had a slight heart attack and they had to keep her in the hospital about three days, three days she was real bad. She got it real bad. … that kinda scared me, … as soon as she went to the hospital I went straight to the house and took that blood pressure medicine.

While some participants mentioned having supportive friends, others did not discuss their health with anyone other than their mother. The relationship between the participants and their mothers appeared to be the strongest connection. Some reported that their mother was the only one aware of their diagnosis. Participants either viewing their diagnosis as a weakness or believing that only they or their mother could help, so why bother anyone else with the details, could explain hiding their diagnosis from others. One participant shared that many of his friends and family did not know of his condition. When ask why, he replied,

> You gotta be close in order. I got a couple of best friends that know and my mother and father and maybe one, a couple of cousins, other than that I don't share that with everybody, then everybody be, they ain't gonna help me deal with it so I'm gonna have to deal with it on my own.

Greg has been diagnosed less than one year. He depended on his friend, also recently diagnosed with HTN, to recommend a physician. They both wanted to learn more and wanted to

find a doctor to "conversate" with them about their blood pressure. If participants choose to open up, friends seemed to be the individuals they could build camaraderie with to learn about HBP.

Thematic Conclusions

Two themes were identified from the analysis: denial and frustration. Although denial is common reaction to health issues, frustration either is new or has been relatively unobserved in the perceptions of healthcare experiences. The frustration experienced by these men may be more evident because they were experiencing a new diagnosis and still exploring their perceptions of their clinical experiences.

The constructed model of the findings from this study (Figure 4.1) depicts the participant experiences and responses related to the clinical diagnosis. Responses to the diagnosis were expressed as denial and fear. Although other research has identified denial as a response to a new diagnosis, no reports were found describing fear as a response to a new diagnosis. In contrast, research has reported Black men as demonstrating masculinity and strength in response to poor health rather than being scared or fearful. These natural responses may be viewed as influencing their engagement in self-care decision-making to participate in health promoting behaviors.

Two important elements of the clinical experience—knowledge and understanding, or in some cases lack of knowledge—can determine patients' level of engagement in self-care to affect health outcomes. The level of support and motivation also may influence their actions to promote good health. While knowledge alone does not constitute successful disease management, adding support and motivation greatly improves the potential for managing the condition successfully. When there is a lack of knowledge, minimal support, and insufficient motivation, the failure to manage the condition is inevitable. Experiencing an unmanaged condition can lead to frustration. Participants in this study demonstrated their frustration by

expressing their many questions that went unanswered and their need for resources and assistance that remained unmet.

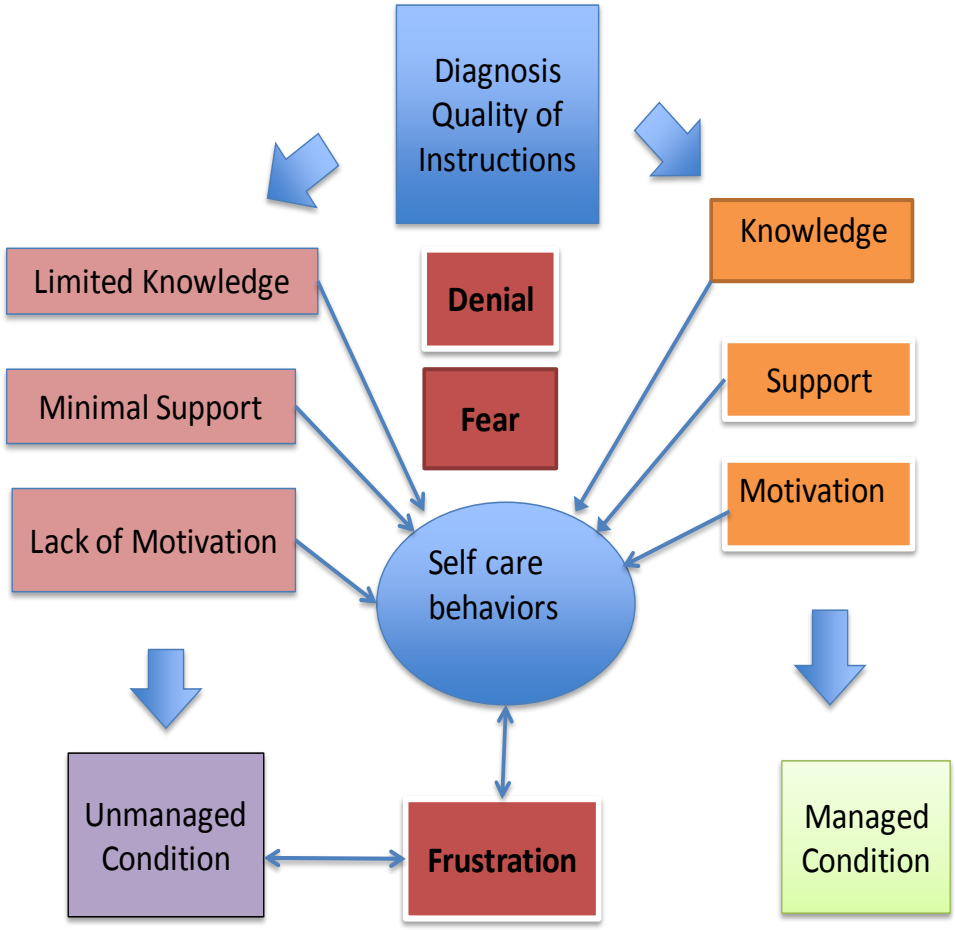


Figure 4.1 Constructed Model of the Thematic Conclusions

Even motivated participants with support, who thought the HCP had informed them about their condition, demonstrated frustration. Their frustration came from struggling with self-care behaviors such as taking medication. Participants did not want to stop smoking or take medication and became frustrated with the long-term commitments managing their condition required.

The model represents a collectivized participant experience. While it does not apply specifically to each individual participant, there was a high degree of consensus on these themes. The fear expressed by these participants had a different quality than fear described in other research. In this study, fear was expressed in the form of reacting with fright and distress when remembering the CVD crises (such as heart attacks, strokes, and early deaths) experienced by participants' family members and friends. They did not want these things to happen to them, but were unable to get the knowledge, resources, and support needed to manage their HTN.

Denial

Denial is not a novel concept for patients reflecting on a new diagnosis. In their study about patient understanding of HTN risks, Weaver et al. (2006) identified participants as either deniers or acceptors. In this study, most part participants could be classified as deniers, as they indicated they did not often think about their diagnosis. However, those who had experienced major health events, such as a heart attack or a stroke, were more inclined to accept that HTN is an unavoidable reality in their lives. One participant stated,

> I'm the type of person that has to experience some kind of catastrophic event before I do right … I don't want that to happen, you know, I don't want to have a stroke and then be like 'oh well now let me get my blood pressure under control.'

This participant had experienced trips to the emergency room to lower his blood pressure, yet continued to struggle with medication compliance, weight management, and dietary adjustments.

"It's not my time." While most participants recognized that HTN ran in their families, they denied that it could happen to them at this time in their life. Forty-four year old Ben said of his clinical experience, "[my] wife at that time asked more of the questions that was going on with me cause, like I said, at that time you young, you don't really care." Age was mentioned frequently as a factor in developing HBP. "You only get high blood pressure when you reach a certain age, you know, or as you get older." One participant said he must have been trying to trick himself by "thinking, I was too young or misdiagnosed or whatever." While another acknowledged he had HBP, he said, "I'm too young to have a stroke or heart attack." As participants shared stories about cousins and friends who had suffered from HTN related illnesses, including a few fatal cardiovascular events, the reality that their own condition could lead to serious illness was dismissed as though it could only happen to someone else.

Frustration

The second theme, frustration, was clearly expressed throughout the interviews. Participants reported being frustrated with the lack of HTN-related education and resources, and their own lack of success in managing their condition. Ken, who was diagnosed four months earlier, was taking his medication and trying to eat right, but he wanted to know "when the headaches are gonna stop." Others, like Jay, needed to "know what the best thing I should do to, uh, bring [the elevated blood pressure] down permanently." These men expressed that they are trying to manage the condition, yet they continue to have health concerns, which adds to their fear of suffering an adverse event.

Lack of knowledge. Most participants were not focused on learning at the time of diagnosis. One participant acknowledged, "I was suppose to been listen[ing] to them." Curtis said his experience in the clinical setting could have been better "if I was paying attention … I was just ready to get the treatment … and leave the hospital." Many participants reported seeking information about HBP. In many cases, participants revealed that the need to learn more about their HBP motivated their participation in this study.

It was clear that many of the participants did not get a clear understanding about HTN when they were diagnosed. Odes rationalizes his condition stating,

> I was kind of stressed is the reason why I had high blood pressure. I wasn't drinking no water and, you know, things like that and I'm thinking that where it comes from, or where it came from so, you know, because I ain't never had high blood pressure.

Experiencing stress at the time of diagnosis could contribute to poor understanding and a lack of focus. When asked what information was provided at the time of diagnosis, participants had a variety of responses. Some received written information to read at their leisure, while others received no information other than the fact that they had HTN. A few went on the Internet for information. Most participants made statements indicating they needed to know more about their condition. Comments such as "I wanted to look into it, you know, to see what I could do to help with it" or "I need to know more."

Odes almost pleaded to understand his diagnosis,

> It could have been better by me knowing … what to do, you know, having high blood pressure. Yeah, just knowing what to do … so I be more comfortable with, you know, and just wouldn't have to worry about it and do what I can to keep my blood pressure down … I really just want to know … what I can do, you know, to help, to cause me

> having high blood pressure, you know, cause I never had high blood pressure. And I thought that … you only get high blood pressure when you reach a certain age, you know, or as you get older, but, you know, but young like I am having high blood pressure and I want to … take care of my body. I just want to, you know, do what I can while I am young, you know. Be healthy, live healthy so, you know, I just really want to know, I want to get familiar with … high blood pressure and how to control it.

This passage indicated Odes' desire to understand and seek help for his condition. Unfortunately, without a primary care provider, financial support, or insurance, many of these men do not know where to turn for assistance.

Seeking follow-up care could have provided additional learning opportunities. However, when asked about their initial experience and potential follow-ups visits, most had responses similar to Andy, who stated,

> I was suppose to been listen to them … I was suppose to went back, but I never went back to talk to them. They was talking to me about my health, you know, at least what I need to do, at least, it was a nurse.

Participants who were given warnings prior to being diagnosed with HTN now see that ignoring the condition does not make it go away. They understand that HBP is a part of their life and they are responsible for managing it. Jay acknowledged that awareness is a major component in practicing prevention. He stated,

> Just being aware. You know, it's already something in you genetically, so just, be aware of the disease. You know, you do preventive measures, you know, to live longer. Because when it boils down to it, it is your life …and your health.

Now participants express the need for more information that provides them with tools that can improve their future health outcomes. Odes continued to share his desire to know more, stating, "I just really want to know how, how could I see that, see the problem of having high blood pressure. How could I? What is the thing I should do that would help me?". Sharing this desire for knowledge, Lars states, "If I can find out more" and others, like Ken, state "I just want to know more".

Lack of resources. In most cases, lack of follow-up care was due to participants' lack of a primary care physician. One participant diagnosed in the past year did not have a good working relationship with his physician and was seeking a new doctor to help him better manage his condition. Not having trust in or effective communication with a doctor adds to the difficulties of learning you have HBP. Pat reported that his clinical experience "… was frightening because I didn't understand what being diagnosed with high blood pressure really meant. I didn't understand the consequences." Like others, Pat did not receive adequate information from his HCP at diagnosis. Whether due to a lack of time, trust, or communication, the men believed they were left with minimal information to manage their condition.

The lack of financial resources and insurance also contributed to the failure to receive necessary treatment. Ken talked about trying to eat healthy "but it's been kind of hard because I don't hardly got no money." Jay admits to his lack of desire to visit the doctor, but states the main reason he does not seek professional care is "I don't have any insurance." Other participants believed that their condition could be better managed with access to adequate resources.

Fear

While many participants knew what they needed to do, their actions did not reflect this knowledge. Seeing the devastating effects of HTN related illnesses in their families and friends left many participants feeling dread about their future health. Believing that HTN has "come" to them too early in life was "depressing" to some and brought "shock" and "fear' to others.

Punishment. Participants viewed HTN as another stressor in their lives. Reflecting on his life struggles and questioning why he has to go through different things, Mack stated, "I think I have been punished enough." Referring to HTN as punishment shows a lack of understanding about the disease.

Making adjustments. Many of the participants believe the positive adjustments they have made should offset other persistent negative behaviors such as smoking or eating fatty, fried meats. One participant said he adds green beans to his pork to make it healthier. Although participants believed they were making positive adjustments in their diet, they also reported many negative choices: drinking sugar and caffeine-laden colas, tea, and coffee; and eating high sodium luncheon meats and canned foods. Most of these participants could benefit from additional dietary education.

"Forget about it." Andy summed up this theme by saying, "Sometimes you just say forget about it, but, you know, I don't want to forget about that cause … I know that's my problem and that's what I have … and I don't want to live that way. It *scares* me real bad." When the participants thought about their HTN, it often reminded them about the fear they experienced at diagnosis. While forgetting their condition may reflect the false hope of it going away, many participants acknowledged knowing that HTN is a life-long struggle and only they can make the changes necessary to control it. Andy is one of the participants who reported taking

his medication and trying to eat right. It was evident that fear was a factor in his desire to manage his condition.

Control. Most participants spoke of wanting to take charge of their health management. Many felt weakness was not an option. For some taking medication was viewed as being weak. Jay said, "I don't want to be seen as, like I need it (medication) or something." Another participant shared, "I feel as a man … I should be able to deal with things." Several participants reported a fear of losing control over daily choices. They did not want to do something because someone else told them to, but because they decided it was the right thing to do. The need to maintain control was apparent as participants reported doing things *their* way. This could have been the result of their wanting to demonstrate their masculinity or to disguise their fear of the disease or lack of knowledge about what to do to improve their health. Rationalizing their role in personal health management may have been a way to disguising their fears of HTN.

Rationalizing. Some participants struggling with HBP management seem to be fooling themselves. Lars said, "I am going to have to deal with it, but I choose to deal with it at a different level, that's all." Odes rationalized his condition when he said,

> I was kind of stressed is the reason why I had high blood pressure. I wasn't drinking no water and, you know, things like that and I'm thinking that where it … came from so, you know, because I ain't never had high blood pressure.

Several participants believed that not drinking an adequate amount of water was the main reason their blood pressure was elevated. During the interviews, I found that instructions to drink more water generally came from the participant's mother or other family members. A review of the literature produced no scientific support for this recommendation to treat HBP.

Conclusion

The demographics provide a snapshot of the seventeen participants who have been living with HBP over the past six months to three years. Regardless of age or education level, their experiences have similarities that may be common to other men in this population. The context of their stories is believed to influence their actions and choices today. Many of the men have seen the loss and suffering from HTN-related illnesses. They have heard the stories passed down through generations of family members struggling with a condition that is prevalent in the Black population. Knowing that HBP runs in their family is distressing, but learning at a young age that you have the disease results in fear and shock.

No matter how nice or polite the healthcare professionals are at the time of diagnosis, there were still uncertainties and questions that needed to be addressed. Some may not have liked the recommendations and others believed that the medical team did not provide them with the information and support they needed to manage their HBP. In this study, participants reported a dislike for taking medication to manage their condition. The exception to this belief was generally from participants who had suffered a heart attack or stroke or had a close loved one who died from one of these illnesses.

Making lifestyle adjustments to prevent HTN related illness was not consistent. Most participants indicated some dietary modifications or at least trying to reduce sodium and fat intake. Weight management was a delicate topic for participants who were obviously overweight. Many made excuses for their current size. In addition to rationalizing their weight, participants generally cited a physical reason that limited their activity. Playing basketball or football was the most widely expressed exercise. Others reported walking to promote heart health and reduce blood pressure.

Smoking was a major health problem for several participants, while a few had never smoked. Most of the smokers were trying to quit or at least reduce the number of cigarettes they smoked. The several participants who reported being alcoholics admitted eliminating alcohol is a constant struggle for them. Others reported trying to limit alcohol intake. These lifestyle modifications presented challenges for the participants and caused stress in their lives.

Participants reported that their friends, family, and faith provided encouragement and assistance. Most participants had known about HBP for a long time. However, once they began trying to manage the condition, their limited understanding often produced negative health outcomes. For some participants, their efforts were not effectively managing the condition, which caused them to feel frustrated. Some rely on God to provide good health. Others shared that they lean on their friends and family, especially their mothers, to help them deal with the fear, denial, and frustration that was evident in their stories.

The thematic conclusions identified were denial, fear, and frustration. Denial is a common finding among patients experiencing a new diagnosis. For these men, age was a major factor in denying HBP was happening to them. Only older people were supposed to have HBP, yet many of them acknowledged seeing cousins, brothers, and sisters suffer the ill effects related to HTN.

In contrast, participant frustration often was due to a lack of information about HBP and a lack of motivation for managing the condition. Many participants believed that if they could get their blood pressure under control, they would be cured. This lack of understanding was evident throughout the stories. A lack of resources—such as medical care, health insurance, and financial means—was viewed as a barrier to achieving good health and added stressors.

Facing these challenges on a daily basis led to fear and feeling punished. Participants who reported making ineffective lifestyle adjustments that they considered sacrifices shared their doubts that successful management was achievable. Participants' attempts to regain control, rationalize, or forget the problem were not helpful. Many participants lacked emotion as they told their stories, which could be due to the doubt and frustration they felt from having HBP and being unable to make it go away. Several participated in the study in the hope that they would learn something to make their lives better, which was one of the goals of this study.

Chapter Five: Discussion

Introduction

The purpose of this study was to increase nursing and interdisciplinary knowledge regarding the clinical experience at the time of the HTN diagnosis from the perspective of Black males, aged 18 to 44 and to investigate how this experience influenced their life choices after diagnosis. Chapter four presented the findings from the stories shared by 17 Black male study participants. In this chapter, I will discuss how the findings answered the research questions and reflects on the influence of clinical experiences in promoting blood pressure management. Next, recommendations for nursing and healthcare practice, policy implications, and ideas for future research promoting improved health outcomes for the study population are presented.

The Research Questions

The guiding question for this study was, "How do Black males recently diagnosed with HTN describe their life experiences and post-diagnosis health behaviors, when reflecting on their perception of the clinical experiences at the time of their diagnosis?" The subset of questions used during data analysis were

- What is the perception of the clinical experience when being diagnosed with HTN?
- What is the experience of individuals newly diagnosed with hypertension and what choices do they make regarding their treatment plan?
- How does the perception of the clinical experience influence treatment plan adherence?

Perception of the Clinical Experience

The first subset question asked about the participants' perceptions of their clinical experience. It was easy to understand that the participants diagnosed during a hospital or

emergency room visit for heart attack or stroke were grateful to the clinical professionals for stabilizing their illness. The positive responses regarding interactions with HCPs may reflect participants' appreciation for the medical treatment they received when they were *scared* of the unknown, but also may have suspected their diagnosis, which included high blood pressure.

In contrast, some participants believed they were treated well but were not given the information or assistance needed to manage their condition. Thorne et al. (2010) contended that the diagnosis visit is a critical time that sets the stage for illness management going forward. Failure to provide a treatment plan or providing a generic plan that does not meet the needs of the patient can be viewed as a missed opportunity.

Some participants reported that the HCP did not engage with them at the diagnosis visit. A lack of assurance that their diagnosis was accurate or the HCPs were knowledgeable about HBP caused doubt and frustration for some participants. In one instance, clinic personnel were unable to locate a participant's medical record, which prevented him from continuing medication therapy. These negative perceptions and reported inefficiencies reflect the social-cultural interpersonal disconnect documented within the academic-medical setting (Mount et al., 2012). At diagnosis, HCPs have an invaluable opportunity to interact with a newly diagnosed patient in a supportive, educational manner that helps promote lifelong learning of effective management strategies. Although being treated respectfully and professionally during the clinical encounter is important, findings from this study indicate a need for medical professionals to provide educational support and follow-up.

Experiences of Living with HTN

Dietary management. Changing dietary choices was the main strategy participants used to manage their HTN. Unfortunately, the examples shared demonstrated a lack of knowledge

about healthy food choices. Their creativity was impressive and indicated that they were trying to take positive steps. One red flag was the lack of understanding about what constitutes "too much salt." It is fair to assume that these men, along with a majority of the general public, do not know how many grams of salt is an acceptable daily allowance or even how many grams they are consuming each day. If this is the case, how can medical professionals expect patients to reduce sodium consumption? The knowledge gap presents an opportunity for dietary consultants, nurses, and other HCPs to educate patients in the healthcare setting about sodium consumption recommendations for disease treatment and prevention.

It is well document that the culturally influenced diet of the Black population is problematic for HTN management (Kennedy et al., 2007; Kumanyika, Whitt-Glover, & Haire-Joshu, 2014; Newton et al., 2014; Peters et al., 2006; Rose et al., 2000). These study participants may be further challenged by their inability to afford healthy foods. Most men were at the church to obtain food from the food pantry. The food pantry's inventory, which may or may not include healthy foods, depends on the surplus food available to the church each week. With limited dietary choices, consuming a healthy diet may not be a realistic option for these men.

Physical activity and weight management. Opportunities to engage in physical activity such as walking and participating in sports were mentioned by many of the participants. However, co-morbidities can limit involvement in a regular exercise program and require the development of a treatment plan customized to an individual's capabilities. Obesity is reported to be a major contributor to HTN in the Black population (Fuchs, 2011; Paschal et al., 2004). Black men have a higher prevalence of abdominal adiposity than White people and Black females. This characteristic may be attributed to dietary choices and the lack of physical activity.

Physical activity is important for cardiovascular health, even for individuals who are not overweight. Participants with and without weight problems could benefit from instruction on how to begin and maintain an active exercise program that benefits their cardiovascular health. Whitt-Glover et al. (2014) reported on the low rate of physical activity among members of the Black population compared to other racial/ethnic groups. Lack of participation in health promoting physical activity and weight management may contribute to racial health disparities in the U.S. Evaluation of the participants' stories indicated a strong need for education, coaching, and motivation that promotes physical activity. For those experiencing weight management problems, developing an acceptable and realistic plan to manage weight and promote exercise would be beneficial.

Tobacco use. The participants who smoked claimed to be trying to quit or decrease the number of cigarettes they smoked. These stories indicated the need to educate participants about the ill effects of any amount of tobacco smoking. Participants did not understand why smoking is detrimental or that it contributes to HTN, only that the doctor recommended they quit.

Research has linked having control over health concerns to masculinity (Cheatham et al., 2008; Mount et al., 2012). Participants expressed that controlling their health was important to them. Throughout the study, they stated the desire to make their own choices about how to control HBP. The social and financial constraints of obtaining and using tobacco products may help with limiting their use. However, it was clear from the interviews that, while education may be helpful, each man has to make the decision to stop using tobacco completely.

Limiting alcohol. A few participants were told to quit drinking all together; others shared how they were limiting alcohol consumption. For some, the solution was to switch from drinking hard liquor to beer. Chartier et al., (2013) reported that increased education helped decrease the

health impact of alcohol consumption among members of the Black population. In this study, most study participants had a high school level education or less. Providing education and exploring barriers to smoking or drinking cessation could help participants examine and improve their coping strategies in order to reduce stress levels.

It is believed that these men's poor choices reflect the many privations they experience in their daily lives. Providing knowledge and resources is the key to enabling these men to improve their health outcomes. Some may be unable to quit unhealthy habits on their own and need outside support. Seeking outside help can be frustrating, as these men do not want to appear weak. Finding ways to change their frustrations into confidence in their ability to manage their blood pressure could help start a trend for improved health outcomes in this population.

Influences from Perceptions of the Clinical Experience

Discussion of the first two subset questions clearly demonstrated the gap between what is learned and what can be learned during the clinical experience to affect subsequent compliance for managing HBP. Most participants concentrated on what they had learned about HTN from their mothers or other family members. Some obtained more information from the Internet. Most expressed the desire to learn more.

The clinical experience was viewed as influencing compliance by providing the confirmation that participants were now among other family members who have HBP. Many participants expressed that *just knowing* about their diagnosis was their first step in HTN management. However, most participants shared encounters with HCPs that extended beyond the diagnosis. Those who were hospitalized had experiences with multiple encounters as did those who returned for treatment and testing after they had been previously diagnosed with HTN. The additional encounters provided depth to their stories, yet the quest to learn more about how to

manage their HBP continued. Even after participants had incorporated some strategies for managing the condition into their daily lives, they still faced the major challenge of learning how to lower their BP readings, which could lead to control of their HBP and improved health outcomes.

Life Experiences when Reflecting on the Clinical Experience at Diagnosis

Although the guiding question of this study incorporated the subset questions, dividing the discussion into the subset questions added clarity to the overall conclusion. In contrast to the Weaver et al.'s (2006) research that focused on how individuals newly diagnosed with HTN understand the condition's risks, this study focused on the clinical experience itself, which revealed various sources of frustration for these participants. This study's interviews revealed details of the clinical experience—how denial and fear influenced understanding of the diagnosis—that were similar to those reported by Weaver et al. (2006). However, after exploring their diagnostic encounter, most participants did not know much more than what family and friends had already told them about HTN. Through their statements, these men expressed the need for more information, guidance, and time to understand how to live their lives with HTN.

When asked how their experience of learning they had HBP could have been better, one participant expressed a plea to know more and gain answers and assistance for managing his condition. He spoke of finding comfort in just knowing what to do. The worry from not understanding how he contracted HBP or how to correct it could result in fear and frustration that prevent him from enjoying his life. His words represented this population's need for access to information about HBP earlier in life, preferably before receiving the diagnosis. Once the diagnosis is made, ongoing conversations and education are needed to promote effective management of the condition.

It is common for adult development to be influenced by life events and experience relevant to a particular age category (Bjorklund & Bee, 2008). This study included men in the stage of early adulthood, when physical and cognitive levels should be at their peak and health related habits become set. However, the majority of participants were transitioning from early adulthood into middle adulthood where physical health begins to decline. This stage brings about new problems that require motivation, determination, and the ability to adapt and cope with health related concerns. Therefore, the experiences participants had prior to and after diagnosis both play an important role in shaping the health related choices. The clinical encounter at diagnosis is the beginning point for the experiences encountered during the lifelong management of HTN.

Evolution of the Research Question

Although the clinical encounter at diagnosis is an important first step to recognizing a health problem and beginning a course of treatment, subsequent encounters and extended encounters, such as hospitalizations, provide opportunities for HCPs to interact with patients. Hospitalization, as experienced by several of the participants of this study, allows for increase nurse-patient interaction with opportunities for patient teaching and assessment to explore patient resources for managing their condition. Encounters with family members and friends who have knowledge of the condition, also influence individual choices. Thus, the guiding question for this study was influenced by the broad description of encounters shared by the participants. The research question evolved into an inclusion of the clinical encounters at and after diagnosis, as well as encounters with others who provided knowledge about HBP. The revised research question was: How do Black males recently diagnosed with HTN describe their life experiences and post-diagnosis health behaviors, when reflecting on their perception of the clinical

experience(s) at and after diagnosis and encounters with family members and friends who share information about living with HTN?

Recommendations for Healthcare Practice

The AHA and the Joint National Committee (JNC 8) post HTN management guidelines for the public and for HCPs. Although the JNC 8 focus is more on the medical management of HTN, both AHA and JNC 8 guidelines confirm the importance of lifestyle changes, including a healthy diet, weight management, regular physical activity, limiting alcohol intake, and not smoking in order to reduce cardiovascular risk (AHA, 2013b; Scordo & Pickett, 2014). HCPs should be familiar with the JNC 8 guidelines when prescribing medication. However, the public may be more familiar with the AHA guidelines and how to access this information via the Internet. Often, brochures, published by the AHA, are provided at health fairs and medical practice clinics to inform the public of cardiovascular conditions. This provides an opportunity for nurses, involved in the patient's treatment plan development, to become familiar with the guidelines and information shared with patients for promoting lifestyle changes identified as important steps toward managing HBP.

In this study, the participants' unfamiliarity with AHA (2013b) guidelines led the PI to consider whether HCPs are *aware* of current guidelines. One of the most important recent changes was the addition of pre-hypertensive category that indicates a patient's increased risk of developing HTN and suggests helpful health behavior modifications. This addition is particularly relevant to this study's participants, as members of the Black population experience a greater rate of progression from pre-hypertension to full HTN (Selassie et al., 2011). Another consideration is that pre-hypertension may not be an effective warning for this or any population, as it is not widely discussed. While these considerations cannot be confirmed by this data, they provide an

opportunity to raise awareness in healthcare practice. It is important for all HCPs, regardless of specialty, to be familiar with the latest HBP guidelines from the AHA and CDC.

Because assessment of blood pressure is a common, non-invasive measurement done in many practice settings, it is important for HCPs to be knowledgeable about HBP and provide adequate information to individuals with an elevated blood pressure reading. Information should be written at an appropriate reading level for the client and should also be presented verbally. HCPs also could invite a family member, perhaps a mother, to hear the information, since some of it likely will be forgotten or ignored due to denial, fear, or other reactions resulting from learning of their condition. A support person might ask relevant questions and request referrals or guidance in obtaining resources to assist in HTN management. In cases of new diagnosis, clinicians might consider designating an HTN specialist who could discuss the treatment plan and respond to patient questions. Such a specialist would be an excellent resource for patients and free up physicians or nurse practitioners to see other patients. Shaw et al. (2014) recommended a team approach to HTN that used a nurse-managed protocol for outpatient disease management. In the hospital setting, a team-based approach also could be an effective management strategy. In this scenario, when prompted by doctor or nurse request, an HTN specialist visits and educates hospital patients newly diagnosed with HTN or those with an HTN related illness.

In the absence of access to an HTN specialist, the participants felt that allowing patients time to ask their doctor questions could contribute their understanding and help them manage their condition. Scheduling a follow-up visit or providing a follow-up a phone call could emphasize the importance of BP management and allow patients to ask questions that arose after

leaving the medical facility. If a follow-up visit is not planned with the diagnosing HCP, patients should be given other options for accessing healthcare services.

Policy Implications

Lack of knowledge was a major problem identified in this study. Although HCPs diagnosed participants in a clinical setting, they received limited and inconsistent information. Some received written information while others did not. Beyond public awareness and prevention campaigns, developing standards for distributing information to individuals newly diagnosed with HTN could be a crucial step in bridging the HTN knowledge gap (CDC, 2014; Clarke, 2010; SurgeonGeneral.gov, 2011). Such standards should be accompanied by the expectation that, in addition to providing the information, the HCP should assess the understanding of patients and the individuals advising them about their condition. Follow-up standards, such as providing a question/answer session, could be developed at the church or public organization, city, county, or state level. To increase awareness, population-based approaches should include multilevel, multicomponent, and socio-environmental elements (Karwalajtys & Kaczorowski, 2010). Integrating services provided by public health and clinical facilities could promote an effective management plan that also provides resources for individuals with HTN and other CVD related conditions.

Public health interventions often occur at multiple levels (Brownson, Seiler, & Eyler, 2010). Upstream interventions that affect large populations involve policy approaches, while midstream interventions occur within organizations, such as work-based programs. However, much of what was explored in this study deals with the downstream or individual-based factors that stem from lifestyle choices. To affect these individual behaviors a multi-level approach is appropriate. From the participants who were incarcerated at the time of their diagnosis it was

learned that the organizational approach provided a structured program to support and educate the newly diagnosed individual. This midstream intervention was successful as long as the person was incarcerated; yet upon the prisoner's release there was no program to reinforce successful management. In Tennessee, a gap of coverage exists for those who do not meet the requirements of a government insurance plan. This places the burden on the community to provide resources for individuals who lack resources, but have health care needs.

Another gap in health care services is the lack of primary care providers to follow individuals with conditions such as HTN, diabetes, obesity, and other conditions that increase the risk for target organ disease. Participants of this study indicated that they either did not have a primary care provider or they did not engage in follow up care for various reasons. A list of non-profit medical clinics was provided to the participants, yet only one was located in the area where they live. One clinic to service a large area does not provide adequate coverage, thus the infrastructure in this area could benefit from city, county, and/or state support to improve the services and access to care.

In addition to the access to care, the use of social services to evaluate individual needs, linking persons to resources for medications and healthy food choices would be beneficial. The community-based service offered by the faith-based food pantry is limited in what food choices they may provide, as their supply is based on what is available from overstocked vendors who donate perishable goods to the pantry. In addition, many donations include canned foods, some of which are very high in sodium content, and are not as high in nutrition as are fresh fruits and vegetables. Thus, a means to improve community efforts for growing and accessing healthy food choices would be helpful. In some locales, this has been done through community-based garden projects, with much success in increasing access to produce, accompanied by a sense of

community achievement and pride. Pharmaceutical companies who offer programs to provide necessary medications to those who cannot afford the medication could provide beneficial support to a community-based program. Such a program would require a multi-level, interdisciplinary approach. For example, the USDDHS (2014b) provides a website listing drug assistance programs such as RX Hope, Partnership for Prescription Assistance, and State-wide Drug Assistance Programs. The site also contains a link where interested persons may obtain drug coupons and rebates based on their income. Providing knowledge of assistance programs and facilitating access this information could be provided by members of the multi-disciplinary team to further assist individuals in managing their condition.

Another program example is The National Center for Health Promotion and Disease Prevention (NCHPDP), which is sponsored by the Veterans Administration (VA) to assist veterans' in promoting good health and being informed (U.S. Department of Veterans Affairs, 2014). Veterans Administration Medical Centers (VAMC), including the Memphis-based VAMC, have implemented programs based on the NCHPDP recommendations. Using an interdisciplinary approach a Massachusetts VAMC implemented a program to increase physical activity. The program manager reported surpassing the goals set for participation, which was attributed to providing consistency in scheduling, a convenient location to meet, including an orientation for new participants, and making reminder phone calls to promote attendance. Similar programs focusing on individuals with HTN delivered at a community-based level, identifying community resources and community leaders to promote the program could influence improved health outcomes.

Prevention and screening clinics may be the most productive and effective venues for city, county, or state government efforts. Screening that starts early in life, even in high school,

and includes ongoing education, could benefit members of this study's focus population. A clinic-based, organized curriculum designed to educate mothers regarding how important their role is viewed by their sons, even in adulthood, would be innovative, and based on a strength of Black families. Such a program would emphasize to mothers how to monitor and care for their personal health and to help those around them to do likewise. These clinics and associated programs would be instrumental in assisting the public to navigate and access resources. Very simply, this study showed that knowledge is pivotal to HTN prevention and improving health outcomes.

Future Research

This study's findings generated opportunities for future research that could provide additional insight into the information HCPs share with newly diagnosed hypertensive patients. A study that linked healthcare settings' HTN education efforts to patients' health outcomes could help identify the most effective strategies currently being used to serve this population. A study of this nature likely would have implications for developing requirements for clinical settings.

All HCPs should be familiar with AHA's recommendations for managing HTN and include them in individual treatment plans as appropriate. Research that examines how HTN treatment plans are delivered to newly diagnosed patients, how thoroughly they are explained, and how they are interpreted also could benefit healthcare knowledge and practice. In addition, determining if patients' needs could be met by giving them an opportunity to ask questions and get easy-to-understand responses would be helpful.

Exploring why individuals with a condition commonly known to be affected by tobacco products continues to engage in the behavior could aid in the development strategies to modify this unhealthy behavior. Exploration of patterns and motives for alcohol consumption by the

hypertensive adult also could inform clinicians. A study focusing on stress effects in this population cold provide information relating to their tendency to develop HTN.

A final recommendation is an intervention study where a HBP monthly meeting program modeled on successful mutual help groups, is conducted with an experimental group. At the meetings, individuals with HBP could share their struggles and learn from one another. Monthly speakers could share information and strategies about healthy diets, physical activity, weight management, smoking cessation, and alcohol consumption. Such a program could better inform individuals with HBP, while influencing improved health outcomes.

Certainly, any of these recommendations could be beneficial for any population. However, the paucity of literature focusing on hypertensive Black men aged 18–44 indicates a need to focus on this population. Thus, I recommend further research be conducted with a similar population in order to inform healthcare professionals of their needs.

Limitations

The nature of qualitative research results in specific study limitations. Replicability is a documented weakness of the qualitative research design (Brink & Wood, 1998). New experiences can change a person's mind, beliefs, and positions. Because life experiences can change an individual's response to an interview question, it would be impossible to return to the same participants, ask the same questions, and get the same responses. In this study, participants were asked to recall experiences that happened from three months to three years prior. Participants' ability to remember could affect the accuracy of their responses. Researcher individuality could make reproducing this study problematic.

Transferability of these findings is limited by the subjectivity of the experiences shared and the geographical region where the study was conducted (mid-south United States). The

nature of self-reporting an HTN diagnosis also may be a study limitation as there was no verification with the medical facility, staff, or medical record. All but one participant in this study were recruited from a faith-based food pantry where blood pressure clinics are held on a regular basis. Consideration should be given to the nature of participants' attendance at the food pantry, to seek assistance and possibly to access the clinic services. This could further limit the findings to those who are actively seeking to learn more about HBP. The sample size of the study was relatively small in comparison to the large number of individuals in the population (adult Black men diagnosed with HTN between three months and three years prior), which decreases the potential for generalizability.

When considering generalizability, researchers should consider the likelihood of individuals with similar characteristics having similar experiences. Perceptions of Black males <44 may not be perceived the same as men >44 or as Black females. Another limitation is that qualitative analysis inhibits the researcher from drawing valid conclusions regarding prevalence of events, even when data can be divided into specific categories such as age. The PI's race and gender, a White female, which affect her cultural and ethnic beliefs and assumptions, also may be a limitation when interviewing someone of another race and gender.

Data obtained in the study are highly dependent on participants' ability to recall and share their experiences. The ability to articulate their experiences and the level of perception may vary among participants (Creswell, 2009). In addition, mental, physical, and emotional stress can limit one's ability to recount events. Participants who were diagnosed closer to three years prior or who did not experience a major event at the time of diagnosis may have had more difficulty recalling their clinical experiences. The clinical settings and healthcare providers were varied thus limiting the findings based on differences in healthcare practice.

Another limitation to consider is that the majority of the sample was recruited from a single venue where participants were seeking assistance. Since a weekly blood pressure clinic is available at the recruitment site, the participants may have been seeking information about managing their condition. Black males not attending a blood pressure clinic may not have the same level of interest in the study topic, as did these participants. Black males who do not need to use a food pantry likely are more affluent than this sample, of whom 70% had annual incomes below $10, 000. The subset of young Black males interviewed for this study is perhaps one of the most vulnerable due to their socioeconomic constraints. While qualitative research is based on the participant-researcher exchange, the method also allows for flexibility. Despite measures taken to combat it, consideration must be given to the potential for researcher bias as well as the self-reporting nature of the participants' information.

So What?

This study was conducted in the hopes that HCPs can view the results as a challenge to become more sensitive to the needs of all the patients they serve. From this study it was learned that a lack of communication and understanding at the critical point of diagnosis and afterwards can lead to an unmanaged condition, thus to make an impact on future health outcomes knowledge and understanding are major components of a team-based approach to provide ongoing education and support for men such as these in the study and possibly could benefit others with HTN. Reactions of denial and fear when diagnosed were identified in previous studies, yet fear was not previously identified as a reaction of Black men. The tendency to display strength and masculinity had been reported as Black males' usual response to health problems. The frustration identified in this study was a response to living with a new diagnosis of HTN in younger Black males. Participants pointed to a lack of knowledge and support. They

spoke from the standpoint of not knowing what to do. Struggling to lower blood pressure without success was not reported in other research. My analysis reveals key components for improving health-care practice: (1) HCPs engaging in ongoing learning and development to provide culturally sensitive care, (2) Clinicians providing improved communication and assessing patients for understanding to promote healthy choices, (3) HCPs understanding the patients' perspectives and gaining their input when developing the treatment plan, (4) HCPs and public health officials identifying resources and promoting engagement in follow-up care, and (5) Communities taking on a multi-level, multi-disciplinary approach to HTN management.

Conclusion

This study provided information about an understudied population and led to several conclusions about what they face when diagnosed with a new health condition. Exploring the stories to uncover the participant perceptions of the clinical experience as an influence on their health behaviors gave unique insight into their experience of denial and frustration when trying to manage their blood pressure. Expanding the research question to include the clinical encounters at and after diagnosis, and the encounters with family members and friends would enlarge the frame to include more influences, facilitators and barriers to treatment adherence and lifestyle changes.

The lack of knowledge and resources these men reported brought attention to the clinical settings where diagnosis occurs. Two recommendations for HCPs were formulated based on these finding: HCPS should provide current, standardized information to patients newly diagnosed with HTN, and HCPs should develop a plan for assessing patients' understanding of the information and guidance they received. These recommendations also may be useful for HTN specialists serving in hospital or clinical settings. HTN specialists could consider

expanding their duties to include coordinating monthly HTN management meetings with the aim of improving health outcomes.

Policy implications include adopting stricter standards for providing knowledge and assessing the understanding of individuals with new HTN diagnoses. Establishing accessible and free public prevention and screening clinics would reach lower economic groups. The clinics could be an extension of a county, city, or state health department.

This study introduced opportunities for future qualitative and quantitative research. Other researchers should consider continuing research with Black men aged 18–44 due to the limited knowledge available about this population. Studies to explore information provided at diagnosis and of what the treatment plan includes would give insight into clinical practice. In addition, the patient's understanding of this information should be measured to validate its effectiveness. A study of alcohol and tobacco use in relation to stress and HTN could provide information. Finally, a clinical trial and effectiveness study could inform city, state, and federal governments about the need to establish monthly HTN education and motivation programs.

The overarching goal of this study was in line with the current healthcare goals that encourage individuals to practice prevention, a choice influenced by education and motivation. The men interviewed for this research represent a small sample of the many individuals who suffer from HTN and HTN related illnesses. Using their words to describe and interpret how healthcare can improve general practices in the diagnosis and treatment of HBP provides an opportunity for practitioners to take actions that can make a difference. While it is easy to become complacent within healthcare practice, this study was conducted in the hopes that HCPs can view the results as a challenge to become more sensitive to the needs of all the patients they serve.

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Appendices

Appendix A – Research Recruitment Flyer

THE UNIVERSITY of TENNESSEE KNOXVILLE
COLLEGE OF NURSING

Got High Blood Pressure ???
If you have been diagnosed with High Blood Pressure in the past 3 years please read on:

You are invited to participate in a research study about your experiences in "Living with Hypertension"

Description of the Project: We are researching Black men's perceptions of the office or clinic visit where they were told they have high blood pressure and where told what they needed to do to control their blood pressure. The purpose of the study is to gain understanding of how the experience at the time of diagnosis is perceived and how this experience may influence the first 3 months to 3 years of life with high blood pressure.

To participate you must be:

- Black or African American
- Male, 18 to 44 years of age
- Diagnosed with High Blood Pressure by a Doctor or Nurse Practitioner
- Diagnosis was at least 3 months ago, but not more than 3 years
- Be English speaking and consent to a 1 hour recorded interview at an agreed upon location

Participation is voluntary. All information is *confidential*. *Minimal risks* of distress or loss of confidentiality will be protected against during and after the study is completed. Participants will receive a $25 gift card for participation in the study. There are *no direct* personal *benefits* yet sharing your information may increase personal awareness regarding your high blood pressure diagnosis and potentially assist health care professionals to improve clinical practice for serving others within your population who are diagnosed with high blood pressure in the future. *Participants may withdraw at any time during the study.*

To learn more contact the principal investigator, Glenda Feild, Doctoral Candidate at 901-820-6501 or gfeild@utk.edu.

Appendix B – Interview Questions

Interview Questions

1. Tell me what it was like for you to be diagnosed with high blood pressure.
2. What led you to seek medical attention?
3. How did the personnel treat you where you were diagnosed?
4. Did you feel respected and well treated by the doctors and nurses you talked with?
5. What instructions or information were you given when you were diagnosed?
6. How has that information or experience been helpful to you today?
7. What were you told about side effects either from taking the medication or from having hypertension?
8. What side effects have you experienced?
9. What side effects concern you the most?
10. What has the doctor told you can be done if side effects occur?
11. What choices do you see yourself as having if side effects occur?
12. What information or support have you received from other people such as friends or family since you were diagnosed? (probe for peer pressure to take or not take medication or to get medical attention leading to diagnosis)
13. Day to day, how is it for you to be living with high blood pressure and any other health problems?
14. How do you think the experience could have been better for you?
15. Is there anything else you would like to tell me about your experience of being diagnosed with high blood pressure?

Appendix C – Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Title of Research Project: Living with Hypertension: Experiences of Black Men related to their Perceptions of the Clinical Diagnosis

Principal Investigator: Glenda M. Feild, PhD(c), MS, BSN, RN

As a member of this research team, I understand that I may have access to confidential information about study sites and participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study sites and participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information, from any source including but not limited to written and audio recordings, obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study sites or participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information, unless specifically authorized to do so by approved protocol or by the principal investigator acting in response to applicable law or court order, or public health or clinical need.
- I understand that I am not to read information about study sites or participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I agree to notify the principal investigator immediately should I become aware of an actual breach of confidentiality or a situation, which could potentially result in a breach, whether this is on my part or on the part of another person.

_____	_____	_____
Signature	Date	Printed name
_____	_____	_____
Signature of principal investigator	Date	Printed name

Appendix D – Informed Consent

INFORMED CONSENT STATEMENT

Living with Hypertension: Experiences of Black Men as Related to Their Perceptions of the Clinical Encounters at Diagnosis

INTRODUCTION

You are invited to take part in a research study. Before you decide to participate in this study, I would like to share why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask the researcher if you have any questions.

The purpose of this study is to learn more about the experiences of men newly diagnosed with high blood pressure. High blood pressure affects a large percentage of people in the Black community. Complications from high blood pressure can lead to other health issues. Controlling high blood pressure is vital to health. We want to know more about your perception of your experiences from the time you received your diagnosis of high blood pressure to the present as it relates to having high blood pressure. Learning more about the different ways Black/African American men respond to be diagnosed with high blood pressure might help us to identify effective strategies for promoting wellness that are sensitive to the needs of your community.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY

It is expected that about 15 men will be interviewed for this study. The time requested of you is no more than one and one-half hours. I have allowed 20 to 30 minutes for you to review the informed consent document, complete basic information sheet and have your blood pressure taken and one hour for the interview. Upon your consent to participate, I will ask you to complete basic information such as your age, marital status, education level, income level, insurance status, and questions pertaining to your diagnosis.

_____ Participant’s Initials

I would like to take your blood pressure before beginning the interview. This measurement is for informational purposes only and could be a benefit to you. Should your blood pressure be high I will provide you with a referral list to seek further medical evaluation. I will not share your results with anyone not directly related to this study. Declining to have your blood pressure taken will not interfere with your participation in the study.

In the study, I will ask you questions for you to share information about your life now that you have been diagnosed with high blood pressure. Your responses to these questions will be recorded and later transcribed for purposes of the research. Recordings will be made using a voice or audio recorder. No video will be taken. If you are willing to participate in a follow-up interview, you can indicate your interest by checking that option on the basic information sheet provided. Everyone will not be asked to participate in a second interview. Second interviews will be requested based on the analysis of the study data. However, everyone has the right to be notified of the study results. You may request to be contacted when the results of the study are completed to discuss the findings.

RISKS

The risks of the study are minimal. These risks are similar to those you experience when disclosing health information to a medical doctor or nurse practitioner. The study is voluntary. You may decline to answer any or all questions and you may end your involvement at any time. Minimal risks such as distress and/or potential for loss of confidentiality are possible occurrences of the study. Should you become distressed it is important to remember that you may stop the interview at any time. You might also be concerned of losing your privacy. Your privacy will be protected during and after the study. A more detailed discussion on the steps to protect your privacy is discussed in the section titled confidentiality.

_____ Participant's Initials

BENEFITS

There will be no direct benefit to you for participating in this study. However, it is hoped that the information from the study will have potential for the following possible benefits:

- You may benefit from sharing your stories learning more on the importance of keeping your blood pressure under control. You may also gain an awareness of what has happened in your life since learning of your high blood pressure that could help or hinder your health.
- Findings from this study may benefit other members of the Black community and specifically people diagnosed with high blood pressure in the future.
- The findings from this study will add to the body of nursing and health care knowledge for enhancing interventions to address cultural and gender sensitivity.
- Having your blood pressure checked at the time of the interview, which is optional, may provide you with a current reading and you will have referral sources given to you at that time. Seeking further care would be your decision.

CONFIDENTIALITY

The information in the study records will be kept confidential. Data will be stored securely and will be made available only to the principal investigator, dissertation committee members and potentially a transcriptionist unless you specifically give permission in writing to do otherwise. No references will be made in written or oral reports linking you to this study. Your comments will be kept confidential at all times.

Every effort will be made by the researcher to preserve your confidentiality including the following:

- Random identifiers will be assigned for all participants. A combination of numbers and letters will be used to identify participants in researcher notes and documents. The PI will maintain the master list in a locked file accessible only by her. The file cabinet will be located in the PI's home office.

_____ Participant's Initials

- Notes, hard copies of interview transcripts, demographic forms, consent forms and any other participant information will be kept in a locked file cabinet in the PI's home office to be accessed only by the PI and committee member through the PI. Electronic copies will be password protected. The data will be kept until the end of publication of the study for reference purposes, approximately one year, and then will be destroyed. Consent forms will be stored in the faculty advisor's (Dr. Hall) office for three years after the study is completed. After this time, the documents will be destroyed.
- Computerized files will be maintained in a password-protected computer file to be accessed only by the PI. Any transfer of these files to members of the dissertation committee or to a potential transcriptionist will be through a secure network file that is password protected.
- De-identified information from this study will be available only to the researcher and members of her dissertation committee. The researcher and members of the committee will be required to sign confidentiality statements prior to receiving any study information.
- Information from this research will be used solely for this study and any publications that may result from the study. All reports, such as journal contributions or presentations to the medical community, written or oral will not identify any participant of the study. General references to the data will not provide any information to link participants to the study. The use of quotations is common in the reporting of qualitative research. Direct participant responses used to support findings will be used without any type of identifier in a broad context to avoid any link to the participant.

Each participant has the opportunity to obtain a transcribed copy of his interview. You can indicate your desire and provide information necessary to provide a transcribed copy by signing a separate consent attached to this form.

Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents or threats to harm self or others and suicide risk.

_____ Participant's initials

RESEARCH INCENTIVE

A $25 gift card will be given to all participants who participate in the study. Participation is defined as completing one interview with the PI. This is not compensation for the study, but may allay time and transportation costs for the participant. Participation is voluntary and thus the card will be given for incomplete interviews, if the person declines further interviewing.

CONTACT INFORMATION

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Glenda Feild, MS, RN at 234 Germantown Bend Cove, Cordova, TN 38018, and (901) 491-7030.

If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you may otherwise be entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

The interview questions are planned to encourage you to share your experiences on the same topics as other participants for understanding the similarities and differences. Response to all questions in the interview are requested; yet, if you choose not to answer any or all of the questions that you are asked you will not be penalized.

_____ Participant's initials

CONSENT

I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

CONSENT FOR AUDIO RECORDING

I understand that my participation in the study will be recorded. I agree to allow the researcher to make an audio recording of my interview for the purpose of this study.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

CONSENT FOR BLOOD PRESSURE MEASUREMENT

I understand that taking my blood pressure is optional and does not determine my participation in the study. I agree to allow the researcher to take and record my blood pressure for informational purposes only.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

CONSENT FOR FOLLOW UP INTERVIEW AND REVIEW OF FINDINGS

I understand that a second interview is optional and does not determine my participation in the study. I agree to allow the researcher to contact me for participation in a second interview where the findings of this study will be reviewed. The researcher may contact me using the following:

Phone or Text or Email (circle preference)

Email or Number _____

Participant's signature _____Date_____

Investigator's signature _____Date_____

REQUEST FOR TRANSCRIBED COPY OF INTERVIEW

I understand I have the right to obtain a transcribed copy of my interview. This copy may be emailed or mailed to my address provided below. I wish to have a copy of my interview transcript sent to:
Email_____

Or

Mailing address _____

_____ City _____State _____Zip Code

Participant's signature _____

Investigator's signature _____

Appendix E – Demographic Questionnaire

Basic/DEMOGRAPHIC QUESTIONNAIRE

I have signed the Consent Form agreeing to participate in the study of Living with Hypertension: Experiences of Black Men Related to Their Perceptions of the Clinical Encounters at Diagnosis that has been approved by the University of Tennessee Institutional Review Board. I understand that my responses to this questionnaire are voluntary and that I can choose not to answer certain questions. Furthermore, I understand that I will not be identified by name in any research or publications resulting from this study.

Name: (printed) _____

Signature: _____

Date: _____

Please provide one answer for each of the following questions:

1. What is your age? _____

2. What is your marital status?

- **Single, never married**
- **Married or living with significant other**
- **Divorced, separated, or widowed**

3. What is your educational level?

- **Less than 12th grade**
- **High School Graduate or completion of the GED**
- **Some College**
- **College Graduate**
- **Graduate level degree, please indicate type _____**

4. What is your current household income?

- **Under $10,000**
- **$10,000 - $14,999**
- **$15,000 - $24,999**
- **$25,000 - $34,999**
- **$35,000 - $45,000**
- **Over $45,000**

5. What is your insurance status?

- **Uninsured**
- **Partial, inadequate insurance**
- **On disability insurance or government sponsored insurance**
- **Private Insurance**
- **Insured by Employer**

6. Where were you diagnosed with high blood pressure? (Name of clinic, hospital or other facility),_____

7. Who discussed your diagnosis with you? (Check all that apply)

- **Doctor**
- **Nurse**
- **Family member**
- **Friend**
- **Other (list)_____**

8. Did you receive any written information about high blood pressure when you were diagnosed?

- **Yes**
- **No**

If Yes, describe the type of information provided _____

Appendix F – Information Sheet for Participants

If I have HBP, what can I do to take care of myself?

There are eight main ways you can control your blood pressure.

They are:

- Eat a better diet, which may include reducing salt
- Enjoy regular physical activity
- Maintain a healthy weight
- Manage stress
- Avoid tobacco smoke
- Comply with medication prescriptions
- If you drink, limit alcohol
- Understand hot tub safety

Adopting a healthy lifestyle is critical for the prevention of HBP and an indispensable part of managing it. Think of these changes as a "lifestyle prescription" and make every effort to comply with them.

Whether you have been diagnosed with high blood pressure, also called hypertension, or are concerned because you have some of the risk factors for the disease, understand this: while there is no cure, **high blood pressure is manageable**.

By adopting a heart-healthy lifestyle, you can:

- Reduce high blood pressure
- Prevent or delay the development of HBP
- Enhance the effectiveness of blood pressure medications
- Lower your risk of heart attack, heart disease, stroke and kidney disease

Here's how to do your part:

- **Be informed**
  Of all people with high blood pressure, over 20 percent are unaware of their condition. This silent disease could leave them with substantial health consequences. Are you one of them? If you don't know, see a healthcare professional to be tested.
- **Do your part to reach your treatment goals**
  Consider these statistics regarding those with known HBP:
  - 69.1 percent are under current treatment
  - 30.9 percent are not currently under treatment, even though they know their blood pressure is high

There is no healthy level of high blood pressure. Don't take life-or-death chances with this disease. Instead, take responsibility! Work with your healthcare professional to determine your treatment goals and map out your best action plan for HBP prevention and management.



Stay Physically Active

- **Change your life and reduce your risks**
  Even if your blood pressure is normal (less than 120 mm Hg systolic AND less than 80 mm Hg diastolic) and your goal is prevention only, the lifestyle modifications provide a prescription for healthy living.

  If your resting blood pressure falls in the pre-hypertension range (systolic - top- number between 120 and 139 mm Hg OR diastolic - bottom - number between 80 and 89 mm Hg), your doctor will recommend lifestyle modifications.

  Lifestyle modifications are essential
  These changes may reduce your blood pressure without the use of prescription medications.

- **Take medication if it is prescribed for you**
  If your blood pressure is 140/90 or higher, your doctor will likely prescribe medication in addition to lifestyle modifications. Follow your healthcare professional's recommendations carefully, even if it means taking medication every day for the rest of your life. High blood pressure is a lifelong disease, and by partnering with your healthcare team, you can successfully reach your treatment goals and enjoy the benefits of better health.



Once your treatment program becomes routine, maintaining a lower blood pressure is easier. Remind yourself that by managing your blood pressure, you are lowering your risk of heart attack, heart failure, stroke, peripheral artery disease and kidney disease. Death rates from these diseases have decreased significantly, thanks in part to earlier and better treatment of HBP.

Managing blood pressure is a lifelong commitment; make a pledge to do so starting today for yourself and for those you love. Listen to your doctor, read the sound medical information on this site, and act on the information to live a heart-healthier life.

"This content was last reviewed on 04/04/2012."

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/PreventionTreatmentofHighBloodPressure/Prevention-Treatment-of-High-Blood-Pressure_UCM_002054_Article.jsp

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Appendix G – Sample Letter to Participants

Sample Letter to Participants

August 16, 2014

Dear Mr._____,

Again, I would like to thank you for your participation in this very important study related to men's health. Learning more about those newly diagnosed with high blood pressure will be helpful for health care professionals to assist you and others in meeting critical health goals to improve health outcomes in the future.

Attached please find a copy of the transcript of my interview with you. Should you have any questions or comments please feel free to contact me at 901 491 7030. It was a pleasure meeting you and I wish you the best in meeting your goals to stay healthy.

Regards,

Glenda Feild, PhD(c), MS. RN

Appendix H – Sample Field Notes

Example 1: This interview was conducted on Saturday morning at the location of a church based food pantry. The participant came to me after learning of the study and shared his desire to participate. We moved from the large fellowship hall where approximately 50 people were waiting to be processed through the line for receiving food items to a small clinical room in the back of the waiting area. The room contained a hospital bed, a supply shelf, four chairs, and a card table. From the room muffled sounds of the activity outside the room could be heard, yet the participant was attentive. The participant was a large Black man with signs of weakness on his left side. His left eye was partially closed from a recent injury and he held his head to one side making limited eye contact as though trying to hide the injured eye. He was very soft spoken and polite. He shared emotion when speaking of his children and demonstrated an affection for the children and grandchildren. We sat facing each other from the corner of the card table where he often leaned on the table during the interview. There were no pictures on the wall or bright colors giving the atmosphere of the interview a clinical feel. The participant showed emotion when speaking of his children as he smiled and had a softness about him. When speaking of things he needed to do his look was not happy or light, but heavy and sorrowful. Once during the interview someone from the food pantry entered the room for supplies and the interview was briefly paused during this time.

Example 2: Today's interview was conducted at the Public Library. The setting was a private study room with two glass walls looking toward a study area that was basically unoccupied. The participant brought his six months old son with him. The child was in an infant seat throughout the interview, making only a few sounds during the interview, and was virtually unnoticed. The participant was very matter of fact in the way he spoke. He was a large Black man with a great personality. He is very knowledgeable of many things and stated he uses the Internet to learn more about symptoms he is experiencing and to learn more about HTN management. Aside from his mostly jovial attitude throughout the interview he demonstrated

concern and seriousness when discussing things that he should be doing to manage his HTN, his mother's lack of healthful behaviors, and his trip to the emergency room for an extremely elevated blood pressure. He acknowledged responsibilities of having a wife and two children who depend on him should facilitate health-promoting behavior. There were minimal interruptions as he was distracted a few times checking on the baby and his cell phone rang at one point in the interview.

Appendix I – Sample of PI's Journal

Journal Entries Prior to Data Collection

- My personal experience of being diagnosed with HTN began during a visit to the doctor for an upper respiratory infection. The physician encouraged me to keep an eye on my blood pressure, yet it was not of primary concern to me. Thus, I failed to monitor my blood pressure and did not pay attention to my diet and did not add exercise to my daily routine since I was not overweight. I was aware that my father and grandparents had high blood pressure and seen the effects of one grandfather who suffered a stroke. A follow-up visit confirmed a HTN diagnosis with instructions to reduce my sodium intake.
- I knew I had *episodes* of HTN, but it was not until a few years later that I was put on medication to management my blood pressure.
- I believed medication would control my HTN thus I continued to consume fried and fatty foods, as it did not affect my weight at that time.
- After conducting extensive research, I am much more informed and take my condition more serious including diet and exercise.
- I think I will find a lot of complacency in my research.
- Looking back, I see missed opportunities with the HCP I encountered.

Journal Entries During and After Data Collection

- I see opportunities to teach more on side effects and risk factors.
- Questions I asked myself based on my difficulties in recruiting – Do these men fear admitting they have HTN? Is it not worth their time to participate in a research study? Do they avoid the study thinking if they don't participate, it will not be real that they have HTN?

- When asking potential participants who do not meet study requirements to share a flyer with a friend who might qualify, the answer I get is "I don't have any friends." I am not sure how to interpret this.
- My fourth interview revealed a different type of educational opportunity when diagnosed at the correctional facility clinic. Here ongoing learning about HBP and health occurred as long as the individual was incarcerated. I think there should be away to assist a transition health needs once the person is released into the public.
- Most participants smiled or chuckled when the discussion of side effects specifically mentioning sexual impotence. I am unsure whether this is an embarrassment reaction or has to do with masculinity or both.
- Several participants have expressed concern and interest demonstrating a real thirst for knowledge. The discussions after the tape was turned off and we began reviewing the AHA guidelines were very in-depth further confirming their need to seek answers, to get help where they could.

Vita

Glenda McCartney Feild has been a Registered Nurse for 26 years. She began her career in nursing after obtaining an Associate Degree in Nursing from the University of Tennessee at Martin. Prior to becoming a nurse, she was an owner of a long-haul trucking business along with her father while also being employed in the banking industry. Her business experience combined with a nursing degree allowed her to move quickly from being a staff nurse on a medical-surgical unit to becoming the director of nursing in a long-term care facility.

Her interest in quality improvement and effective management allowed her to serve as a leader to her peers in the Tennessee Health Care Association Director of Nursing Affiliate (THCADONA) at regional and state levels. While serving as the state president of the affiliate group, she was received the THCADONA member of the year award in 1993. Later, she accepted a district consulting position serving ten long-term care facilities in Tennessee, Arkansas, Mississippi, Oklahoma, and Texas. This position precipitated a move to Memphis, Tennessee where she became director of a Long Term Acute Care hospital.

Glenda has a long-standing interest and involvement in developing strategies for improving the quality of care delivery. Her passion for knowledge and desire to affect quality improvement influenced her decision to return to school. She obtained her Bachelor of Science in Nursing in 2009 and Masters of Health Care Education in 2010 from Regis University in Denver, Colorado. She was also inducted into the Honor Society of Nursing in December 2009. During her enrollment in the doctoral program at University of Tennessee–Knoxville, she became a member of the Southern Nursing Research Society where she served as a student representative on the program committee for 2012 and 2013. She also is a member of the Tennessee Nurses Association, the American Nurses Association, and the Preventive Cardiovascular Nursing Association.