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Expressed Coping Strategies and Techniques Among African American Families in North Florida Who Are Living with Chronic Hypertensive Cardiovascular Disease

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EXPRESSED COPING STRATEGIES AND TECHNIQUES
AMONG AFRICAN AMERICAN FAMILIES
IN NORTH FLORIDA WHO ARE LIVING WITH
CHRONIC HYPERTENSIVE CARDIOVASCULAR DISEASE

By
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Dedicated to my Mother
whom I miss dearly
Barbara Ruth Jones
(March 25, 1995)

My Maternal Grandmother
Ruby Mae Inex Exion Jones
(June 20, 2001)

My Father
William Van Daughtry Jones

My Paternal Grandmother
Willie Lee Brown

My Father-in-Law
Bobby Lang

Uncles
John Jones, Lamar Jones

Aunts
Yvonne Brav, Mattie Jones, Patricia Pavtee

All have been or are currently known sufferers
of
Chronic Hypertensive Cardiovascular Disease
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ABSTRACT

The purpose of this study was to determine how patients as well as members of their families cope with Chronic Hypertensive Cardiovascular Disease and the problems associated with it on a daily basis. Research was done based on Phenomenological theory because it concerns the nature of the lived experience relative to the disease and family life. I wanted to qualitatively explore perceptions, meanings, effects, and experiences among African American patients and family members of Chronic Hypertensive Cardiovascular Disease, and discover coping strategies and adjustments made for daily life.

A purposive convenience sample of ten participants from five households was the sample population for this study. Of the ten participants, five were patients, two were spouses (i.e., one was female and one was male), one was a mother, one was a sister, and one was a daughter of the patients. All of the participants were African American and resided in North Florida. The ages of the participants ranged from 40 years of age to 85 years old.

The participants were observed and interviewed in the comfort of their own homes to promote a familiar environment and safety. The interviews were recorded, transcribed and analyzed. Social support theory and the health belief model were the framework choices for this study. The frameworks were used to determine how and to what extent morale and hope are strengthen and to determine if a person’s health and behavior are affected by his or her health beliefs.

Eight different over-arching themes prevailed (e.g., fear and anxiety of the disease, dependency on the physician, family background and familiarity, need for family support, need for external support, coping strategies and techniques, socioeconomic
status, and spirituality). Social support regardless as to whether it is in the form of emotional, cognitive, or instrumental, was found to significantly be associated with positive health behaviors such as exercise, medication compliance, diet, regular check-ups and appointment keeping patterns. In addition, if a person believes that taking medication that has been prescribed by their physician will make them better, then they will take it. If patients feel that exercise and diet would be beneficial in decreasing either their vulnerability to or the harshness of the condition, and if they believe that the probable costs of taking action are outweighed by benefits then they will comply. Education plays an important factor as well. Patients knowledgeable about his or her disease will help influence medication compliance, exercise regimen, and diet, which will increase patient progress toward healthy living.

Fear and anxiety proved to be the center core of all the themes relative to CHCD. Because of fear and anxiety about the disease, the patients and caregivers showed the dependency and belief they have in the physician. Paradoxically, that fearful state of mind had a positive effect of making the patient more aware and familiar with the disease. Also, because of fear and anxiety, the patient depended a great deal on family and external support in terms of coping strategies and techniques. It was also found that even though a patient may have close ties with family, they must interact with individuals outside the family structure (external support). This may be through agencies, health care providers, or just through some individual who has a kindred spirit and a concern for the circumstance.
CHAPTER 1

INTRODUCTION

Cardiovascular diseases together comprise one of the prominent disease states in the world. It is ranked as America’s number one killer, claiming the lives of 40 percent of the more than 2.4 million Americans who die each year (American Heart Association, 2002). There are several kinds of cardiovascular diseases. Among the diseases are high blood pressure (i.e., hypertension), arteriosclerosis, congenital heart defects, coronary artery disease, stroke, rheumatic heart disease, and peripheral vascular disease (American Heart Association, 1996). The diseases affect many individuals, across gender, race, nationality, and in many instances, are present in young adults and children. It is a source of concern to physicians, other health care providers, and public health agencies. Additionally, lay person discussions often lead to disbeliefs and misconceptions about hypertension because there is little or no education in the general public.

There is a high prevalence of hypertension in ethnic minority populations, with the disease disproportionately affecting people of African descent throughout the diaspora, especially among African Americans (Society for Women’s Health Research, 1991). It is the number one cause of kidney failure and end-stage renal disease, and is a major contributor to stroke and heart attack according to the Report of the Secretary’s Task Force on Black and Minority Health (U. S. Department of Health and Human Services, 1985). No one knows the causes of idiopathic hypertension, but researchers have learned of some risk factors that increase the chance that some people will develop malignant hypertension. Some of these risk factors are controllable such as eating too much salt, lack of exercise, alcohol, obesity, and stress, and some are uncontrollable such as race, heredity, and age (American Heart Association, 1995). In recent years, increasing numbers of scientists and health care practitioners are finding that high blood
pressure is frequently associated with high sodium intake or body salt retention (Dial-Benton & Jones, 2001).

Both in the aging African American population as well as in younger individuals, chronic diseases such as hypertension, diabetes, rheumatoid arthritis and their associated health problems are commonly found. It is also not uncommon to find at least one individual of a nuclear or extended family diagnosed with chronic hypertensive cardiovascular disease. Subsequently, in most instances, patients and family members have to deal with the rigors of coping with the associated problems of the disease on a daily basis.

Clearly, individuals adopt varying levels and techniques of coping in dealing with everyday life situations. The superimposing of a chronic illness, coupled with normal ups and downs of everyday life, create a source of concern and hardship for not only the family members, but also for the patient. In most instances, the hardship is associated with the disabilities of the disease which most often, but not always, occur later in life when individuals are not as capable and resilient as in their younger days. Hence, social, economic, and psychological factors impact the family and complicate the pathophysiological profile and outcomes of living with the disease.

In the literature, mechanisms and patterns of coping have received much attention relative to common situations, learning, family problems, and chronic illnesses. However, only a few of these studies have addressed the social impact of hypertensive cardiovascular disease on African American families (Morisky, Levine, Green, Shapiro, Russell, & Smith, 1983; Haber, 1986), and even fewer studies have addressed coping strategies and techniques employed by African American families relative to hypertensive cardiovascular related diseases. Historically, the focus of research relative to cardiovascular disease has been primarily in majority populations although the highest proportion of hypertension remains in African Americans. This demonstrates a classical situation of information void and illustrates a need to analyze all aspects of the coping phenomena that are exemplified in this major group of hypertension disease sufferers. Pearlin and Schooler (1978) defined coping as “things that people do to avoid being harmed by life strains and stresses” (p. 2). McCubbin, Joy, Cauble, Comeau, Patterson and Needle (1980) later extended this definition to “family coping” as being “the group’s
management of a stressful event or situation” (p. 855). Boss (1988) put an explanatory spin on the meaning stating “if one member of the group (i.e., family) exhibits distress symptoms, then the family as a whole is not coping functionally” (p. 60). In the literature (Dyk & Schvaneveldt, 1987; McCubbin et al. 1980), the family system as a whole and the individual patient are seen to be involved in the process of coping. Therefore, both individual and family components should be evaluated in studies dealing with coping. Disease processes are known to trigger changes in lifestyle and behavior of patients, which often affect the lives of family members and exacerbate strains and stresses. These in turn may promote needed adjustments in coping processes and mechanisms. In fact, careful and direct observations of families in their normal environment demonstrate that large segments of family life change from their normal routine; often to a point of severe emotional stress and difficulty in understanding new situations created by the illness of the individual family member (Storer, Frate, Johnson, & Greenberg, 1987).

Hypertension is a disease that affects how individuals see themselves and how they relate to family members, especially if there are complications with the disease. In such situations, actions of patients and family members are influenced by experiences, and by the individual’s potential or skill as well as the family’s potential or skills for actually coping. These “family coping strategies” are derived from intrinsic (i.e., inborn) adaptive capacities (Reiss & Oliveri, 1980).

Since essential hypertension is an incurable disease, its course is often unpredictable and its treatment extremely demanding. The patient and the family members are faced with the health problem for life. Frequently, anxiety, depression, inadequate control of blood pressure and presence of other disease processes appear over time in several cases of hypertension. Family coping strategies can then be expected to be adjusted over time to meet the situation. In this regard, individuals and family members may differ in their adjustment to both the illness and to the patient as a person. Physical health of all members of the family of the hypertensive patient may also be a determining factor in individuals developing suitable coping strategies.

Efforts to improve coping have been proposed as a means of assisting ill patients by helping them maintain some reasonable emotional state and well-being that would not severely affect the rest of the family (McCubbin, Joy, Cauble, Comeau, Patterson, &
Needle, 1980). In this regard, several studies (Dyk & Schvaneveldt, 1987; Reiss & Oliveri, 1980; Stetz, Lewis, & Primomo, 1986) have indicated that choices of coping strategies (for individuals of the family) influence the emotional outcome of stressful events (such as illness of family members) and may be the determining factors in how well the patient responds to care. This remains a concern for health care providers, social scientists, and families.

**Statement of the Problem Area**

An important overall theme is family and individual coping in relationship to hypertension. More specifically, how do African American individuals as well as members of the family cope with chronic hypertensive cardiovascular disease and the problems associated with it? The interest in this area of study is prompted by the fact that family life, interpersonal relationships, and coping skills are contingent upon disease processes, often resulting in changes that affect the entire family throughout the course of the disease. Moreover, differences in coping strategies and techniques and disease awareness may influence patient progress, medication compliance, and healthy living. This remains a problem in health care with regards to hypertension and many other chronic and debilitating diseases among African Americans.

**Purpose of the Study**

The purpose of this study was to qualitatively explore perceptions of meanings, effects, and experiences of chronic hypertension among African American patients and family members. Coping strategies and adjustments made for daily life were the primary focus of the study.

**Theoretical Frameworks**

There are a variety of family theories available to describe family functioning. However, fewer theoretical works have focused on family relationships as associated
with health outcomes. Among the extensive conceptual frameworks that have emerged in family studies, several theories and models can serve as a basis for this research study: (a) ABCX and Double ABCX models (Hill, 1949, 1958; Olson & McCubbin, 1983); (b) FAAR model (McCubbin, Sussman, Patterson, 1983); (c) symbolic interaction theory (Burr, Leigh, Day, & Constantine, 1979); (d) phenomenological theory (Van Manen, 1990; Moustakas, 1994); (e) social support theory (Depner, Wethington, & Ingersoll-Dayton, 1984); and (f) health belief model (Rosenstock, 1966).

ABCX & Double ABCX Models

There are several models that have been used in conducting research to determine how the family copes during stressful times. The ABCX and Double ABCX models are examples. Hill’s ABCX model (Hill, 1949, 1958) has been one of the more creative models of research concerning how the family responds to stressful situations (e.g., chronic diseases). The ABCX model is an equation composed of a stressor event and the hardships or burdens placed on the family unit. The basic stress equation is ABC=X with (A) the stressor event, (B) the family’s coping resources or strengths, (C) perception of the stressor event, and (X) outcome as shown in Figure 1. The hardships of the situation or event represented by (A), the family’s coping resources or strengths available to meet demands of the stressor event represented by (B) and the family’s definition of the event as intimidating, if the event demands more resources than the family can provide, all influence the severity of the crisis represented by (X) experienced by families. This X factor also represents the magnitude of the crisis experienced by families exposed to stressful events and transitions. The resulting degree of stress ranges from high or strained levels to low or managed levels (Boss, 1988).
In the Double ABCX model (McCubbin, Sussman, & Patterson, 1983), “a” factor becomes “Aa” or “family pile-up.” Pile-up includes not just the stressor, but also previous family strains and hardships induced by the stressor event. Sometimes not only do families have to deal with making adjustments to their diet (i.e., if patient has certain salt or caffeine restrictions), but are also charged with the mission of taking care of the needs of loved ones who have certain abnormalities such as end-stage renal disease or psychological effects brought about by a stroke.

McCubbin, Sussman, and Patterson (1983) outline stressor events as pile-up, also known as the “aA” factor which networks with the family’s adaptive resources known as the “bB” factor and definitions of themselves and their experiences known as “cC” to construct a response to the stressor that either minimizes or maximizes the potential for family crisis known as “xX”. As a result, family adaptation is the outcome of the family’s processes in reaction to the crisis and pile-up of demands.

There are several stressors and strains that can contribute to a pile-up of demands. McCubbin, Sussman, and Patterson (1983) identified: 1) the initial stressor and its hardships, and 2) prior strains, such as unresolved hardships from earlier transitions or stressors that are exacerbated when new stressors are experienced by the family.
However, we know that stress will prevail when an event demands more resources than a family is capable of instantly securing, thereby intimidating the natural equilibrium of the family system needed to advert the stressor.

![Diagram of the Double ABCX Model]

Figure 2: The Double ABCX Model (Adapted from McCubbin, Sussman, and Patterson, 1983a)

**FAAR Model**

The FAAR (Family Adjustment an Adaptation Response) model, which is a refinement of the ABCX model is designed to describe families responding to stressors. It attempts to understand family adaptation by examining three critical stages hypothesized to be involved in that process (McCubbin, Sussman, & Patterson, 1983). These stages are: (a) resistance, or denial or reluctance to admit that change is necessary and inevitable; (b) restructuring, the process of making structural and behavioral changes; and (c) consolidation, or the resumption of stable internal functioning (McCubbin, et al.,
Although there is little evidence of any research conducted in relationship to chronic hypertensive cardiovascular disease using the FAAR (Family Adjustment and Adaptation Response) model, it is known that a lot of times individuals are in denial or unwilling to acknowledge that change is necessary (i.e., first stage) and therefore neglect to take medication prescribed. But through social support, behavioral changes can be made (i.e., second stage), thereby making it possible for the individual to resume a stable lifestyle (i.e., third stage).

**Symbolic Interaction Theory**

According to symbolic interaction theory, human actions are based on the meanings we attribute to things. People learn identities and values through the socialization process as they learn the social meanings that different behaviors imply (Klein & White, 1996). Because roles are socially defined, they are not real like objects or things, but are real because of the meanings people give them. Symbolic interactionists see the human capacity for reflection and interpretation as having an important role in the socialization process.

For symbolic interactionists, meaning is constantly reconstructed as people act within their social environments. Our sense of self is what we imagine we are; it is not an interior bundle of drives, instincts, and motives. Because of the importance attributed to reflection in symbolic interaction theory, a symbolic interactionists uses the term self, rather than the term personality, to refer to a person’s identity.

Symbolic interactionists think people become who they are through their interactions with others. Symbolic interaction seeks to encourage and showcase the study of interpersonal conduct and experience. This theory could be very beneficial in studying a participant’s meanings and experiences with hypertension, because emphasis is given to research that is based upon symbolic interaction, phenomenology, and other qualitative research methods (Burr, Leigh, Day, & Constantine, 1979).

In using symbolic interaction and other qualitative research methods, the researcher uses description and a high level of detail. The researcher tells this story informally as “storyteller” and explores the cultural themes of roles and behavior. He or
she describes the everyday life of a person because the overall format is descriptive.

**Phenomenological Theory**

Phenomenological theory focuses on the nature of the lived experience. On the one hand, it means that phenomenological research requires the researcher to stand in the fullness of life, in the midst of the world of living relations and shared situations. It also means that the researcher actively explores the category of lived experience in all its aspects (van Manen, 1990). In general, phenomenology involves the application of logos (language and thoughtfulness) to a phenomenon (an aspect of lived experience). It is a process of interpretation through reflection. The purpose is to understand the experience of the person, using ideals or examples from the person’s lived world and individual interpretations.

In using phenomenology theory in relation to participants suffering from hypertension, emphasis is placed on understanding the participant’s world through his/her perceptions, meanings, intentions and lived experiences. This theory will be very beneficial as participants render their experiences through story telling (i.e., in-depth interviews), and questionnaires related to coping patterns they have had to endure during their experience with chronic hypertensive cardiovascular disease.

**Social Support Theory**

Social support theory is assumed to impact compliance, which in turn influences one’s well-being. Social support content refers to the type or the nature of social support and may include emotional, cognitive, and instrumental support. It has been confirmed that social support improves a person’s ability to cope with life’s stresses and, as a result, enhances well-being (Cohen & Wills, 1985). Social support has been conceptualized as what a person “draws on in order to cope” (Lazarus & Folkman, 1984, p. 158).

Social support strengthens morale and hope; provides emotional sustenance; enhances abilities to learn and use new skills in new situations; and modifies negative stress. It is considered to play a vital role in the control of blood pressure (Belgrave & Lewis, 1994). It has been noted that patients who receive high levels of social support tend to have lower levels of blood pressure, and patients who receive lower levels of
social support tend to have higher blood pressure levels. Patients tend to adhere to medication prescribed by their physician; patients tend to exercise more frequently; patients tend to watch or monitor their food intake; and patients tend to keep their doctors appointments when social support is provided by family members or other persons designated as caregivers or care providers.

**Health Belief Model**

The Health Belief Model (HBM), one of the oldest health behavior change theories, was conceptualized by Hochbaum and his colleagues in the 1950’s to better understand the failure of many public health programs (Rosenstock, 1966). HBM has been modified so that it is now believed that individuals will take health-protective action if they regard themselves as susceptible to the condition, if they believe it to have potentially serious consequences, if they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition, and if they believe that the anticipated barriers to (or costs of) taking the action are outweighed by its benefits (Rosenstock, 1966, p. 42-43).

It is known that a person’s health behaviors are affected by his/her health beliefs. Whether or not a person will take a provocative role in his/her own healthcare depends on his/her beliefs or those of a family member. A person’s health beliefs and health behaviors must be identified before health providers can aid a person in improving health behaviors.

**Theories Guiding This Research**

The significance of research, relative to the family and to individuals coping with chronic hypertensive cardiovascular disease, is directly related to theoretical bases upon which the research is done. In order to address these issues, appropriate theories will be utilized through this study. Phenomenological theory will be applied because it concerns the nature of lived experiences relative to the disease and family life.

Second, Social Support theory will be used to determine how and to what extent morale and hope are strengthened, and emotional sustenance are affected in this patient population in North Florida. Social support helps an individual to cope or adjust to life’s
strains and stresses. This support can come from a spouse, child, neighbor, physician, as well as an agency. Sometimes socioeconomic circumstances are known to precipitate real changes in behavior and acceptance towards disease and care options. This situation is more pronounced among African Americans of low economic position. One may well see an impact of social conditions on compliance, medication type, and quality of life.

Third, the Health Belief theory puts forward that a person’s health and behavior are affected by his/her beliefs and will be a primary tool of this research. This theory relative to hypertension and African Americans states that the condition introduces consequences that are far reaching to patient outcome and disease awareness.

**Research Questions**

This research study, which is qualitative and phenomenological in nature, was conducted to gather data, and explore meanings and perceptions of personal experiences. The meanings and perceptions of personal experiences regarding chronic hypertensive cardiovascular disease among African American patients and selected family members, was investigated for the analysis and interpretation of the following research questions:

1. What does Chronic Hypertensive Cardiovascular Disease mean to African American patients and primary caregivers in North Florida?

2. What experiences do patients and primary caregivers perceive as most significant in relationship to Chronic Hypertensive Cardiovascular Disease.

3. What coping strategies and techniques do patients and primary caregivers identify in dealing with Chronic Hypertensive Cardiovascular disease?

4. What external influences do patients and primary caregivers believe are important in coping?
Definitions

The definitions below are presented to clarify terminology used in this study in the following categories:

Medical

1. **Arteriosclerosis** – is blobs of cholesterol, fats and other material on the inside of arteries. These fatty blobs enter the inner wall and accumulate there (American Heart Association, 1996).

2. **Blood Pressure** - Blood pressure is the force exerted by the blood against the walls of the blood vessels during the systolic and diastolic. Ideal blood pressure is less or equal to 120/80. Normal blood pressure is that which is less than 130/85 (American Heart Association, 1995).

3. **Chronic Illness** – illness that is of long duration (American Heart Association, 1996).

4. **Congenital Heart Defects** – is a heart problem that starts at birth of a child and may continue throughout adulthood (American Heart Association, 1996).

5. **Coronary Artery Disease** – is fatty blobs of cholesterol and other materials (e.g., atherosclerosis) in the coronary arteries. These blobs narrow the coronary arteries so less blood flows to the heart muscle (American Heart Association, 1996).

6. **Diastolic** - Pronounced (dye-a-stol-ik) represents the lowest pressure that remains within the artery when the heart is at rest in between beats (American Heart Association, 1995).

7. **Hypertensive Cardiovascular Disease** - this means that the pressure in the walls of the arteries is above normal range (American Heart Association, 1996).

8. **Hypertension** - it is another name for high blood pressure and hypertensive cardiovascular disease. Sometimes pressure is elevated all the time. Sometimes pressure is elevated only when in a nervous state. This is called “white coat syndrome”. Stage 1, or mild hypertension is 140-159/90-99.

9. **Idiopathic Hypertension** – is hypertension where the cause is unknown. It is also incurable. It is also known as essential or primary hypertension (Pritchett & Hull Associates, Inc., 1998).

10. **Malignant Hypertension** – is hypertension that is caused by some abnormality (e.g., kidney, heart, brain problems, stress, diet, lack of exercise, alcohol, smoking, and obesity). It is also know as secondary hypertension (Pritchett & Hull Associates, Inc., 1998).

11. **Peripheral Vascular Disease** - refers to diseases of blood vessels outside the heart and brain. It is often a narrowing of the vessels that carry blood to leg and arm muscles (American Heart Association, 1996).

12. **Rheumatic Heart Disease** – is caused by an illness that affects mostly children between the ages of five and 15. It may attack many parts of the body and sometimes scars the heart valves causing rheumatic heart disease (American Heart Association, 1996).

13. **Sphygmomanometer** – pronounced (sfig-mo-ma-nom-e-ter) is an instrument used to measure blood pressure (American Heart Association, 1996).

14. **Stroke** - a stroke is caused by the abrupt loss of blood supply to a part of the brain (ischemia). In some cases, stroke is caused by bleeding into brain tissue (hemorrhage). Stroke also can mean a dramatic change in a person’s ability to live a normal life. It can lead to paralysis, loss of speech, memory, vision, diminished reasoning, and sometimes even death (American Heart Association, 1996).

15. **Systolic** - pronounced (sis-tol-ik) represents the maximum pressure in the artery produced as the heart contracts and the blood begins to flow (American Heart Association, 1995).

**General**

1. **Coping** – Purposeful efforts to manage the situation (Jensen & Karoly, 1991).
The things that people do to avoid being harmed by life strains and stresses (Pearlin & Schooler, 1978).

2. Family - A culturally produced social system made up of two or more people in a primary group living together who are related by blood, adoption, marriage (McCubbin, Patterson, & Wilson, 1983).

3. Family Coping – family coping involves three (3) levels: 1) The individual must be able to resolve, tolerate, and master the demands that tax his/her personal resources; 2) Intra family – subsystems within the family (e.g., husband/wife); 3) Involves the family as a whole (group). Family coping assists in promoting a better fit between family and environmental demands (Dyk & Schvaneveldt, 1987).

4. Family Stressors – are the expected components of development over the life span (McCubbin, Patterson & Wilson, 1983).

5. Family Strains – are those unexpected experiences which create family unsteadiness (McCubbin, Patterson & Wilson, 1983).

6. Social Support – provides emotional sustenance; strengthens hope and morale enhances abilities to learn and use new skills in new situations reduces stress (Belgrave & Lewis, 1994).

7. Stress – a relationship between environment and person, which is appraised as draining one’s resources and endangering well-being (Lazarus & Folkman, 1984).

Abbreviations

1. CV: Cardiovascular
2. DBP: Diastolic Blood Pressure
3. HBM: Health Belief Model
4. SBP: Systolic Blood Pressure
5. CHCD: Chronic Hypertensive Cardiovascular Disease
Assumptions

For the purpose of this study, the following is assumed:

1. Participants will share their views with the researcher, be honest in answering all the questions asked by the researcher, and respond honestly on all questionnaires.
2. Participants will have adequate comprehension levels and will be able to understand questions during the interview and be able to complete all questionnaires.
3. Family and social support is important in order to sustain health.
4. Meanings and personal experiences with Chronic Hypertensive Cardiovascular disease can be expressed and interpreted.
5. Participants will be interviewed on the same day of the week.

Limitations

The study will be limited by the following:

1. The research will be based on a purposive and convenience sample, which limit the researcher from generalizing the results to other groups or populations.
2. Some participants may become tired due to their health status which could lead to less detailed answers to some interview questions.
3. The sample population includes participants identified by cardiologists in private practice and findings may be limited to biases intrinsic in the use of the particular sample selection.
4. Participants who have had a heart transplant were not included in this study.
Delimitations

The study will not address:

1. Patients who have not suffered with hypertensive cardiovascular disease for less than one year.
2. Patients who are under the age of 40 and over 85.
3. Participants who are not African Americans
4. A family member who does not provide a support system for the patient.
CHAPTER 2

REVIEW OF THE LITERATURE

Most studies on hypertension and its related abnormalities in body functions are conducted from a biomedical standpoint. The literature abounds with information on the nature, the outcomes, and therapeutic practices associated with the disease. On the other hand, fewer studies have addressed post hypertension diagnosis, related patient awareness, lifestyle changes, and alterations in patients’ daily activities have on the family.

In many African American households, the latter factors may have more far-reaching implications than in other communities due to sharp differences in socioeconomic conditions including disparities in health care practices. African American’s cultural eating habits consist of a diet high in sodium and animal fat. This diet includes cured meats such as barbecued ribs, chicken, beef, salt pork, bacon and bacon rinds, ham and ham hocks, pork chops, pickled pig’s feet, broiled pig’s feet, pig ears, ox tails, and chitterlings. Most of these foods are relatively inexpensive. Some African Americans’ diet also include many carbohydrates, including rice and gravies, breads, rice and bread puddings, and macaroni and cheese. Also included are such snacks as buttermilk and cornbread mixed together, potato chips, and salted nuts; and such beverages as carbonated sodas, beer, and alcohol.

In addition, most have limited experiences with the medical system. The use of “folk” or “home remedies” has been the traditional way of treating the disease. Yet, these families are known to continue family life through adjustments and coping strategies that go unreported and that may be unique to the culture.

Several areas of the literature are pertinent to the analysis of coping strategies and lifestyle adjustments made by African Americans in relation to chronic hypertensive
cardiovascular disease. The following literature review delves into four of these pertinent areas.

**Hypertension, Cardiovascular Health and Programmatic Approaches**

Several programs have been developed that offer support and guidance for patients with hypertension (Morisky, Levine, Green, Shapiro, Russell, & Smith, 1983; Nader, Sallis, Patterson, Abramson, Rupp, Senn, Atkins, Roppe, Morris, Wallace, & Vega, 1989). In the Nader, et al. (1989) study, the patient’s entire family as a means of preventive or therapeutic practice was addressed. They reasoned that by targeting the family unit a more widespread evaluation of the program’s effectiveness could be made. Furthermore, more long lasting changes in program outcomes were realized by involving the entire family. For example, in weight loss programs, by dealing with the family as a supportive unit, patients lowered their body weight more consistently.

Morisky, Levine, Green, Shapiro, Russell, and Smith (1983) included a majority of African American patients in their preliminary studies. On one hand, they reported high levels of knowledge about hypertension, including risks, compliance, consequences and treatment among that group. On the other hand, the patients had shown confusion regarding their own therapy and had difficulty incorporating it into their schedules because of a lack of confidence in their ability to manage their blood pressure. This suggested a need for the involvement of family members in patient care, and led them to
propose that the ability to cope and the outcomes of the disease are linked to family support among African Americans. Consequently, the importance of family and social support for the patient and family is no longer a question in improving care. Yet, few studies have addressed the extent or types of family and social support interactions among African Americans. In addition, its link to more strategic interventions in patient care is not recognized.

Another program approach by Nader, Sallis, Patterson, Abramson, Rupp, Senn, Atkins, Roppe, Morris, Wallace, and Vega (1989) was school based. They introduced the idea that a school based program on cardiovascular health would require minimal curriculum time and that it would effectively reach individuals of minority descent. Through a family based intervention program of cardiovascular risk reduction, individuals were recognized and their school provided interventions for individuals of high risk. The purpose of the project was to involve the school as a primary institution in health promotion.

Two hundred and six (206) healthy middle income Mexican American and non-Hispanic White families participated in the study. Although there were no African Americans, the results from these groups can be considered to be relevant for African Americans. The participants in the experimental group showed significant improvement in knowledge of the skills necessary to change exercise and dietary habits above those in the control group. Improvement persisted up to two years after the study was completed. Similarly, actual health behavior modifications among families exposed to the interventions of the study were noted. The differences obtained between the family groups were explained on three bases 1) ethnicity and socioeconomic status, 2) cultural and comfort barriers for the less educated that may have been in the measurement procedures, 3) the intervention was not as effective in Mexican American fathers. Nonetheless, the study suggests that intervention techniques, inclusive of education, proper dieting, and exercising routines in families promote a reduction in cardiovascular disease risk.
Hypertensive Cardiovascular Responses to Conflict, Stress, and Social Support

A number of researchers have addressed conflict, stress, and social support (Belgrave & Lewis, 1994; McClure & Myers, 1999; Pennebaker & Watson, 1988; Walsh & Walsh, 1987). The studies suggest that people with chronic diseases such as hypertension often take medications and use health facilities based on their beliefs about their physiological state. Although a sample from Pennebaker and Watson (1988) consisted of a majority of white females, results show that actions of hypertensive patients based on their beliefs may become determinant factors in the coping profile of the patient and their acceptance of care. The effect of stress in family conflict interactions on cardiovascular (CV) responses among African Americans hypertensive and normotensive mother-daughter dyads (McClure & Myers, 1999) were affected by conflict situations. The relation of social support to blood pressure levels (Walsh & Walsh, 1987) also suggested a correlation between coping strategies and chronic hypertensive cardiovascular disease.

Stress

McClure and Myers (1999) examined conflict and stress between African American hypertensive and normotensive mother-daughter dyads and its effect on the cardiovascular system. These researchers suggest that adult African American female hypertensives respond to interpersonal conflict with greater peripheral vasoconstriction suggesting a higher alpha rather than beta-adrenergic receptor hyperactivity, and that family risk is associated with higher blood pressure levels in daughters which may be linked to higher body mass in that group. Also, they suggest that conflict management and body mass may be important factors to consider among families at risk for hypertension.

One question not asked of the hypertensive group was: How is the rest of the family coping with the stress of the mother’s hypertension? One of the reasons that this question is so important is the seriousness of stress related diseases. Stress, as we know
it, plays a role in elevated blood pressure and subsequent cardiovascular disease. Often, the level of stress is the sole cause of high mortality (American Heart Association, 1995). Some individuals appear to be more prone to stress than do others. Being able to predict the damage-potential of this stimulus to pathophysiological change could serve to improve disease prevalence, risk management and mortality, as well as determining coping techniques and patient acceptance. Furthermore, in order to cope with hypertensive cardiovascular diseases researchers note that there is a positive role of the family’s social support in the prevention and attenuation of stress.

**Social Support**

Social support is thought to play a significant role in blood pressure control. In a general sense, social support provides emotional sustenance; modifies negative stress; strengthens hope and morale; and enhances abilities to learn and use new skills in new situations. Hence, social support is a very powerful tool. In addition, it has been found to have a direct positive effect on physical and mental health status, and serves as a cushion for the effects of physical and psychological stress on the individual (Belgrave & Lewis, 1994). Social support can also make the transition to a new environment more successful. Walsh and Walsh (1987) examined the position of social support on blood pressure levels among immigrants. In their study, blood pressure levels among immigrants was explored to determine if adaptation to the host culture is related to differential blood pressure levels.

However, Walsh and Walsh (1987) found that social support was second only to age in its ability to account independently for variance in blood pressure levels. As hypothesized, immigrants receiving high levels of social support had considerably lower blood pressure levels than those receiving less social support. This study suggests the adaptability of stress determinants and coping potential outside of the individual suggesting an influence area for patients with hypertension. Although the sample population did not consist of African Americans, results likely would be similar for any population.

The role of social support in compliance and other health behaviors for African Americans with chronic illnesses was examined by Belgrave and Lewis (1994). The
researchers hypothesized that health behaviors, such as adherence to medication, exercise, and diet would be positively related to social support. Also, appointment-keeping behavior was expected to be positively related to social support.

The samples were taken from two chronic illness populations (i.e., diabetes and sickle cell anemia). The diabetic sample consisted of African American patients attending a diabetes clinic; and the sickle cell sample consisted of African American patients attending a sickle cell clinic at the same hospital. Although this sample did not include hypertensive patients, it identified some of the social support factors that may also be operative in African Americans who are hypertensive.

The results suggest that social support (e.g., emotional, cognitive, or instrumental), is significantly associated with positive health behaviors, i.e., exercise, medication compliance, diet, and having regular check-ups as well as their appointment-keeping patterns. However, the importance of the family along with social support may be invaluable as suggested by the results of Nader, Sallis, Patterson, Abramson, Rupp, Senn, Atkins, Roppe, Morris, Wallace, and Vega (1989) reported in the previous section. The absence of family involvement among African Americans as part of the social support area suggests the need for more in-depth studies to address this issue.

These four studies examined hypertensive cardiovascular response to conflict, stress, and social support and used Anglo Americans, African Americans, and/or immigrants in the population of their studies. However, the majority of subjects were females. In all four studies, the sampling technique was convenience and/or snowball and the cardiovascular responses were objectively measured. These studies suggest that there is no difference between normotensives and hypertensives in accurately estimating blood pressure. Second, hypertensive mother-daughter dyads had higher blood pressures than normotensives. Third, immigrants receiving social support had lower levels of blood pressure than those who did not identify social support; and lastly, appointment-keeping behavior and health behaviors, such as adherence to medication, exercise, and diet is significantly related to social support.

In addition, these studies were descriptive, and their populations varied from middle class Anglo-Americans to low income under educated African Americans and immigrants. The variables studied were blood pressure and social support. Belgrave and
Lewis (1994) also Walsh and Walsh (1987) examined the role of social support; whereas, McClure and Myers (1999), Pennebaker and Watson (1988), and Walsh and Walsh (1987) examined blood pressure levels. Thus, coping with specific diseases or social situations may be correlated to events seen in African American families. Yet, there are only a few studies that address the African American perception of stress and the reality of social support while living with hypertensive cardiovascular disease.

Coping Strategies, Lifestyle Adjustments, and Care Implications

A major area of concern related to coping strategies and chronic cardiovascular disease is actual strategies and adjustments, that individuals with illnesses and their families successfully use. According to Dyk and Schvaneveldt (1987), the key to the concept of family coping involves three levels that must be measured and incorporated into a model. The first level is the individual. He or she must be able to resolve, master, tolerate, or reduce demands that tax or exceed his or her personal resources. The second level can be referred to as the intra-family level. This is the level where the unit of analysis moves to subsystems within the family (i.e., wife-husband, etc.). The third and final level is the family level. This is where the unit of analysis is the family as a whole (i.e., group). This is the level where coping assists in promoting a better fit between family and environmental demands. Ideally, efforts by individual family members, subsystems, and the family unit aims at accomplishing a equilibrium in the family system that encourages individual growth and development (individual level), facilitates organization and unity (intra-family level), and manages internal and/or external demands assessed by the family as exceeding current family resources (family level). Another view of family coping phases is in the FAAR (Family Adjustment an Adaptation Response) model by McCubbin and Patterson (1983). The authors call attention to three phases: 1) resistance, 2) restructuring, and 3) consolidation during which families use a variety of adaptive coping strategies. It is presumed that the
restructuring phase is preceded by the resistance stage. However, families may not proceed linearly from crisis to adaptation. A family might become trapped along the way or follow a recurring path as they work through the situation.

This awareness of the cyclical or recurring nature of the coping process necessarily assumes a process over time. While some stressful situations may be short-term, other situations require family coping over long periods of time as in the case of a long-term chronic illness such as hypertension. Family coping strategies utilized in year one may be or may not be the same strategies utilized in year nine. The dynamic aspect of life-cycle characteristics contributes to the necessity of adapting coping strategies to the current situation. However, the Family Adjustment and Adaptation Response (FAAR) model can be used to demonstrate the dynamics underlying the response families make to the stress imposed by the diagnosis and treatment of high blood pressure or hypertension. As we know, hypertension is a serious and extensive health problem, and the successful treatment of hypertension requires a large number of life-style and behavior changes which can be very stressful to family members as well as the patient (Greenberg, Frate, & Shimkin, 1983).

In looking back over the years, the earliest conceptual foundation was Hill’s (1949) well known ABCX family crisis model where A (the stressor event), interacting with B (the family’s coping resources), interacting with C (the definition the family makes of the event) and X (outcome). The original study implementing this model uncovered additional factors influencing family adaptation including family coping strategies designed to bring about changes in family structure in an effort to accomplish positive adaptation.

McCubbin and Patterson (1983) used Hill’s formulation to advance a Double ABCX model of family behavior that incorporated post-crisis variables including the coping strategies families employ. Coping was identified as a bridging concept that includes both behavioral and cognitive components, resources, perceptions, and behavioral responses as families try to achieve a balance in family functioning. Family coping efforts may be directed at 1) eliminating and/or avoiding stressors and strains; 2) maintaining the family system’s integrity and morale; 3) managing the hardships of the situation; 4) acquiring and developing resources to meet demands; and 5) implementing
As just previously stated, resources are part of a family’s capabilities to meet or reduce demands and necessarily include existing characteristics of individual members, the family unit, and the community as well as expanded resources that are developed and strengthened in response to stressor demands. It is these resources that a family draws upon to meet the demands of life events ranging from normal to disastrous. The family may rely upon individual coping resources, which can include characteristics such as intellectual and analytical skills, self-esteem, and interpersonal and other social skills (Olson & McCubbin, 1982). Family system resources, or the internal attributes of the family unit, can include cohesion (emotional bonding), adaptability (family’s ability to change its power structure, role relationships, and relationship rules in response to situational and developmental stress), and communication (Olson & McCubbin, 1982).

The diagnosis, acceptance, and eventual commitment to a regimen of hypertension agrees with the aspects of the combined Double ABCX and Family Adjustment and Adaptation (FAAR) models. Since hypertension is asymptomatic, diagnosis marks the onset of the stress due to the presence of the disease. Stress is present if the hypertensive individual becomes aware of the additional health risks associated with hypertension. At this point in the progression of the disease, the resources of the family may be viewed as being in possession of sufficient knowledge about the disorder to make having uncontrolled hypertension stressful enough to avoid family resistance and push the family into crisis (or X factor), defined here as the family’s restructuring to accommodate the hypertensive individual’s newly adopted antihypertensive life style. This, of course, would hardly ever happen immediately without some resistance to the structural change. This resistance usually takes the form of denying the seriousness of the problem or expecting behavioral change in the hypertensive without the family’s support and accommodation (Caplan, Robinson, French, Caldwell, & Shinn, 1976).

There can be no victorious adjustment to hypertension, only an adaptation. Denial by the entire family of the seriousness of the condition permits the family to function normally for a limited time, but only at an ever increasing health risk to the
hypertensive individual. Another time-limited adjustment can happen in a situation where the individual’s blood pressure is temporarily controlled by the hypertensive individual taking medication but has not made any other lifestyle changes. In this situation, the hardships forced by medication expense and side effects will eventually lead to reversion to the denial coping strategy or bring the family to crisis and begin an adaptive restructuring. Throughout both of these styles of resistance, the degree of information the family possesses about how closely the patient is in compliance with treatment and the seriousness of noncompliance varies. Whether the family moves toward an adjustment based on denial or an adaptation based on compliance is determined by this (Caplan, Robinson, French, Caldwell, & Shinn, 1976).

Other researchers have dealt with the coping theory problem from the standpoint that health benefits of coping are varied, and that ultimate adjustment to the new situation is dependent upon how and by whom the coping strategies are initiated. As a result, some studies have advocated talking and writing of the stress related problem to assure the coping strategy is in place.

For example, Pennebaker and Seagal (1999), showed that acts of constructing stories about self and personal experiences have important value in the manifestation of disease processes or how individuals respond to stressful events. The principal contention is that the process of writing allows individuals to organize and remember events in a coherent fashion while integrating thoughts and feelings about their present state of being. In a way, the writing act is a form of therapy. Pennebaker and Seagal also found that talking or writing about emotional topics influences immune function in constructive ways, such as antibody response to hepatitis B vaccinations and t-helper cell growth. By writing, individuals simply become more health conscious, and therefore change their behavior accordingly. Writing also allows openness of expression. The act of converting emotions and images into words may change the way individuals organize and think about the traumatic experience. As a result, the translation of experience into a story may have a calming effect with regards to recognition of meaning and implication of health.
Coping with Chronic Illness

Physical health is closely related to emotional and mental health particularly in middle aged and older individuals (Felton & Revenson, 1984). Adaptation to these closely related entities is thought to be related to coping efforts. Typical coping strategies have been shown to include denial, selective ignoring, information seeking, taking refuge in activities, avoidance, learning specific illness related procedures, engaging in wish fulfilling fantasies, blaming others, and seeking comfort from others. Also, there is evidence that choices of coping strategies influence the outcome of stressful events.

Specific types of coping strategies are more or less effective depending on the type of stress being faced. Some coping strategies that have had positive effects on individuals are: 1) learning specific illness-related procedures; 2) information seeking (e.g., looking up medical information; watching television programs about illnesses; finding several solutions to the problem; asking for advice (physicians, etc.); 3) seeking comfort from others; 4) taking refuge in activity, and 5) spirituality. Marty and Vaux (1982) suggest that religious beliefs can help people cope with health concerns, partially because spiritual beliefs help people face issues of living. Other anthropological research has documented the role of the spirituality of the African people in shaping notions of illness and healing as well as its influence on people of African descent throughout the diaspora (Montilus, 1989). Work of several researchers suggests that the use of spiritual resources in health concerns is a form of coping for people of low socioeconomic status (Baer, 1984; Hill & Mathews, 1981).

Some coping strategies that have had negative effects on individuals are: 1) denial, 2) selective ignoring, 3) blaming others, and 4) avoidance. Coping strategies have also been examined as they relate to adjustment (Jensen & Karoly, 1991). In those health situations viewed as uncontrollable the coping strategies become more complex. Indeed, uncontrollability limits the utility of coping efforts directed towards the problematic situation.

Felton and Revenson (1984) evaluated the emotional consequences of using palliative and instrumental coping strategies in patients with chronic illnesses. Additionally, they examined chronic illnesses that vary in controllability and whether
coping skills play a part in adjustments to illness or whether coping behaviors are simply emotional reactions to illness. The study compared non-hospitalized individuals faced with one of four chronic illnesses: hypertension, diabetes, rheumatoid arthritis, and blood cancer. The latter two were designated as less controllable. Two measures of adjustment were made, coping (information seeking and wish fulfilling fantasy) and psychological adjustment (positive effect, negative effect and acceptance of illness).

The results showed that information seeking was linked to decreased negative affect while wish-fulfilling fantasy was linked to poor adjustment or increased negative affect. Although the sample consisted primarily of white, married, middle to upper middle class adults of both genders, it is believed that these research findings could possibly apply to coping strategies of African Americans.

Jensen and Karoly (1991) suggest that there are “control beliefs” associated with coping efforts and adjustment in individual’s acts of accommodation to life situations. They addressed the fact that chronic pain (long defined as pain that persists beyond normal healing time) induces adjustment problems which occur in individuals who appear to function normally with chronic pain while others do relatively better. The question as to what undergirds differential susceptibility to the effects of chronic pain remains unanswered. Recently, models of stress and coping have been utilized to determine, analyze, and explain adjustment differences among pain sufferers. Although the researchers defined coping as being purposeful efforts to manage life situations in spite of pain, a similarity can be made to the situation in which the African American patient copes with chronic hypertensive cardiovascular disease. A more direct interpretation of coping can be described as things that people do to avoid being harmed by life strains (Barusch, 1988). In the latter case, the implication is that the hypertensive patient would have to make even more severe coping adjustments when there is chronic pain.

Coping strategies have also been examined as they relate to adjustment in performance of tasks and the move to more complete functionality (Barusch, 1988; Felton & Revenson, 1984; Jensen & Karoly, 1991; Schoeneman, Rezniko, & Bacon, 1983). These studies previous in this domain have used composite measures of coping and have concluded that coping efforts can be effective when coupled to physical and
psychological functionings.

Other investigations suggest that older individuals become more internal in their beliefs about disease processes and their care. (Krause, 1986; Schoeneman, Reznikoff, & Bacon, 1983). This situation often gives way to differences in coping strategies among these older individuals. Resultantly, personality variables are highly influential in dealing with spouse illness and its related stress among elderly patients. The same situation may be true for African American families.

Schoeneman, Reznikoff, and Bacon (1983) pointed out that a relationship exists between prolonged exposure to stressful life experiences and emotional adjustment. They noted that two frequent responses to stressful events are anxiety and depression, and that a poignant example of a stressor that can precipitate such reactions is the illness of a family member. Thus, living with a chronic illness can be debilitating both to the patient and to family members. The general expectation is that the closer the family member is to the patient the more evidence there is of the function of both patient and family member. Both Schoeneman, et al. (1983) and Barusch (1988) have shown that in the case of a spouse’s illness, the other spouse contributes to the patient’s well being.

Adaptation to the stress of living with a chronically ill partner has been shown to relate to the mental and physical health of the partner. Thus, both the spouse of the patient and the hypertensive patient have to develop coping skills to deal with the chronic condition. For example, Schoeneman, Reznikoff, and Bacon (1983) stated that treatment of end stage renal disease with hemodialysis, requires coping adjustments by patients and family. Hypertension by itself presents as a chronic, potent, and pervasive event. It can be an all encompassing, stressful condition which no one can have complete control. When it results in kidney failure, the required dialysis decreases the behavioral flexibility of patient and family because of its rigorously defined schedule of long and frequent treatments and its strict dietary regulations. It stands to reason that under such conditions, spouses of this type of patient are more challenged to deal effectively with the chronic stress. Clearly then, specific personality characteristics will play an essential role in successful adaptation.

One personality variable, “Locus of Control Orientation”, has been described as having particular promise because it deals specifically with the issue of perception of the
extent to which one feels that one has control over environmental events. Schoeneman, Rezniko, and Bacon (1983) proposed that this personality trait would be extremely useful in determining a spouse’s adjustment to chronic illness of their partners. The locus of control variable was found to be useful in understanding the differences in adjustment of the women in that a greater external locus of control was related to poorer demonstration of adjustment by wives. There was a lack of a positive relationship between an internal health locus of control orientation and a good adjustment. The researchers concluded that individuals’ strong perception that they are in control may not be functional in the face of a truly uncontrollable situation. Thus, an individual needs to make a realistic appraisal of their ability to control a given situation in developing coping techniques.

The study concluded that several clinical implications can be drawn from the results. First, very externally oriented spouses faced with long term stress of living with chronic illness are less likely to adapt as more internally oriented women. Thus, if these women can be identified early and trained, through therapeutic intervention, to become more internal, perhaps their adjustment to their husband’s chronic illness would be better.

Problems and coping strategies of elderly spouse caregivers have also been the focus of research. Barusch (1988) conducted in-depth interviews of spouse caregivers to identify the types of problems and the coping strategies, which were effective for the elderly women. Studies of the elderly, (Barusch, 1988; Schoeneman, Rezniko, & Bacon, 1983) have addressed some significant areas of coping. Of particular relevance to the current study, is the relationship between coping and physical and mental health outcomes (Barusch, 1988). Specifically, when a group of elderly caregivers of Alzheimer’s patients were studied, five coping strategies were identified that reduce caregivers burdens: an internal group consisting of having confidence in problem solving abilities, reframing, and passivity; and an external group consisting of use of spiritual support and the involvement of extended family. As far as coping effectiveness was concerned, the strategies which the caregivers believed were most effective may not ultimately have been the best possible solutions to the problem situations. Caregivers coping responses indicated that they were most likely to seek help particularly with care management (from family members) and health related problems. Caregivers generally reported most success when they changed the situation either on their own or with help.
Procedurally, the self reporting on issues pertinent to coping, adjustment, and care implications allowed for limited generalizations since the sample population was Anglo-Americans. However, these findings can likely be applied to African Americans as they cope with hypertensive cardiovascular disease. As is often the case with chronic disease sufferers, coping involves the individual, the family, and the caregivers. Thus, total adjustment involves the disease, problem solving initiatives and personal outcome expectancies.

In much the same way as coping is seen as pivotal in adjustment by patients to everyday stressors, the family involvement in the coping process must be seen as essential to adjustment plans (Jensen & Karoly, 1991). Few studies have addressed this form of family coping as well as the nature of the total family involvement (Felton & Revenson, 1984; Jensen & Karoly, 1991). Family involvement in the coping process has been studied by Barusch (1988) and Schoeneman, Rezniko, & Bacon (1983). On one hand, Shoeneman et al. (1983) found that wives of hemodialysis patients expressed difficulty in adapting to the husbands’ illness. On the other hand, Barusch (1988) found that a multitude of coping techniques are required by elderly spouse caregivers thereby emphasizing the importance of family involvement in health care. None of these studies were conducted with a sample of African Americans, thus indicating the importance of the proposed study.

**Problem Solving**

Problem solving has been investigated from the standpoint of the individual. Such self-appraised problem solving ability provides valuable information for conceptualizing and developing counseling interventions. At the same time, relevant investigations have linked problem solving appraisal to state and trait anxiety, depression, and overall psychological adjustment. Ineffective problem solving is associated with greater distress under routine conditions and at times of stress. In general, self appraised, effective problem solvers tend to have higher expectancies for control, make fewer attributions of self blame, possess lower irrational beliefs and have high self concept and lower self criticism scores than do ineffective problem solvers (Elliot & Marmarosh,
1994; Krause, 1986; Shoeneman, Rezniko, & Bacon, 1983).

Krause (1986) states the importance of “locus of control” as utilized by several other researchers to articulate the problem. Nonetheless, persons with “external locus of control orientations” believe that they are more or less at the mercy of the social environment, while those with “internal locus of control orientation” believe that they can monitor their own situation and therefore create an active problem solving approach to life. The latter group alters, prepares for, or completely avoids stressful events, and is therefore thought to cope more effectively than externals. Krause also suggests that older adults with extreme internal mastery control beliefs as well as extreme external master control beliefs are especially vulnerable to the deleterious effect of negative stressful events.

Coping Challenges and Experiences
Among Hypertensive Families

There has been an increase in the number of studies on black families in recent years. A stipulation by the National Institutes of Health and other funding agencies requiring the inclusion of minorities in the data pool has positively influenced research in the biomedical sciences. Yet, we know little about ordinary life experiences of black families, because they are still not fully included in the research literature, the treatment strategies proposed by practitioners, and the coverage of families observed in the popular press, television, theater, or policies. Most important, economic stress and its negative impact on black families’ life experiences remain vital areas of research (McKenry & Price, 1994).

Summary

Few studies examine the issue of coping with hypertension in the African American family. In fact, only one article (Belgrave & Lewis, 1994) involved the operation of support systems on the health care of African Americans. Even in that study, the focus was not hypertension as a separate disease, but on a group of chronic
diseases. There is a paucity of literature available in the area of “coping with hypertension” for the group of people who has the highest prevalence of the disease. Therefore, there is a need to further investigate coping with hypertensive cardiovascular disease from an African American and family perspective.

Overall, it was found that in untreated hypertension, the problem of coping by family members can be absent especially when the condition is undiagnosed. A positive relationship exists between medication taking, appointment keeping, and survival rate; and the participation of family members have a positive influence on these aspects of patient care. There are more changes in dietary, emotional, mood and other health behavior modifications in patients who have family support. Socioeconomic and education levels of participants affect acceptance, coping, and adaptation to chronic illness. Therefore, the prevention or attenuation of stress not only provides for emotional sustenance, strengthens hope and morale, but also enhances abilities to learn and use new skills in new situations. These five points coupled with the availability of a new cadre of social and biological scientists can make studies more relevant to research areas such as coping strategies and chronic hypertensive cardiovascular disease in African American families.
This study investigated the meanings, experiences, and coping strategies related to chronic hypertensive cardiovascular disease according to African American patients and family members. The study investigated coping patterns through in-depth interviews, questionnaires, and direct observation. This study relied on qualitative research methods by which meanings, interaction, and context were emphasized. The general approach of this study was phenomenological in nature, with an emphasis on the subjective aspects of each person’s experiences. The researcher attempted to “gain entry into the conceptual world of their subjects in order to understand how and what meaning they construct around events in their daily lives” (Bodgan & Biklen, 1992, p. 34).

Phenomenological methodology was applied because it focused on gaining data that lends understanding into the nature of the lived experience. When applied to qualitative research, it helped the researcher to understand the participants from their own point of view. It is a process of interpretation through reflection. It is an interpretive movement around, through, beneath, into for the essence of the experience (Van Manen, 1990). This chapter addresses the aspects of the methodology: Sample, instruments, procedure for data collection, and data analysis.

Sample

The researcher contacted internal medicine/cardiologists (See Appendix A), then asked permission to invite their patients with chronic hypertensive cardiovascular disease to participate in the study. A purposive convenience sample of five patients (e.g., three females and two males) and each patient’s family member who serves as the primary care
provider in North Florida was observed and interviewed in the natural settings of the participant homes. The power and judgment of purposeful sampling lies in selecting information-rich cases for study in-depth. In-depth information from a small number of the population can be very valuable, especially if the study is information-rich, judged in context (Patton, 1990).

African Americans were selected because they have a higher prevalence of chronic hypertensive cardiovascular disease, and African American women tend to suffer from hypertension longer than African American men (American Heart Association, 1995). It is also noted that African Americans represent approximately 40.8% of the residents in Northern Florida where the research took place (Bureau of Economic and Business Research, 1999).

The patients were identified through the assistance of local physicians who specialized in cardiology and internal medicine in northern Florida, and the family members serving as the primary care providers were identified through the patient. The researcher knows several cardiologists and thought that they would serve as practical gatekeepers who have contact with participants who suffer with chronic hypertensive cardiovascular disease.

Participants (i.e., patients and primary care providers) ranged between the ages of 40 through 85, have suffered or has a family member who has suffered from chronic hypertensive cardiovascular disease for at least one year, and are African Americans. Individuals who fail to meet this criteria were considered ineligible to participate in the study. The criteria ensured that the participants have had enough time and life experience to identify coping strategies and challenges.

**Instrumentation**

In order to collect the data necessary to understand meanings, the data collection techniques included in-depth interviewing, questionnaires, and direct observation.
In-depth Interviews

The interview questions were constructed by the researcher based on phenomenological theory, social support theory, and the health belief model. The dialogue topics were very general, open-ended questions that allowed for maximum story-telling. The following are examples of the types of questions that were asked of the participants during the interviews (See Appendix B): How familiar are you with the disease? How has the disease affected you and your lifestyle (e.g., individual, work habits, family)? How do you cope with the problems brought about by this disease? To what extent do outside agencies and/or individuals help? In your opinion, what could be done to make the present circumstances better? The researcher also probed for specific examples and answers; didn’t settle for yes or no answers. Since probes are used to enhance the richness of the data being obtained, and to deepen the response to a question, basic detail-oriented probes such as “who,” “what,” “where,” “when,” and “how” were used to achieve a complete and detailed image of some experience or activity (Patton, 1990).

The interviews took place in the natural setting of the homes of the participants. The point was to understand naturally occurring family patterns. This path is not tied to a single treatment, predetermined outcomes or goals, but focuses on the actual interactions and impacts of a process. Interviews conducted in a familiar place such as a home facilitated the researchers’ ability to probe and explore African American patients and family members regarding roles, rituals, rules, routines, and relationships. Both patients and primary care providers interviews were conducted at different times on the same day. The objective of interviews is to understand the inner perspective of those being interviewed; and effective interviewing should cause both the interviewer and the interviewee to feel that a two-way flow of communication is going on. The researcher communicated respect for persons being interviewed by giving them the courtesy of explaining why questions were being asked. Understanding the purpose of the interview augmented the motivation of the interviewee to respond openly and in detail. The researcher had the obligation of informing the interviewee at the beginning of the interview of: 1) what was to be asked in the interview, 2) who the information was for, 3) how the information was to be handled, including confidentiality, 4) the purpose of
collecting the information, and 5) how it was to be used.

**Questionnaire**

The questionnaire was used to gain demographic background information, patient medication profiles, living arrangements (e.g., relative to the family), support contacts outside the family (See Appendix C), and most of all coping strategies and techniques practiced by the patients as well as other support systems.

**Direct Observation**

Direct observation data was collected (See Appendix D) in addition to the phenomenological interview process. The rationale of observational data was to illustrate the setting that was observed, the behavior that took place in the setting, the people who participated in the behavior, and the meanings of what was observed from the perspective of those observed (Patton, 1987).

Observation played a role in this qualitative study. Behavior, the end product of knowledge and attitudes, can only be evaluated through observation. By directly observing actions, the researcher gained a better understanding of the context within which the families interact. In addition, first hand experience allowed an opportunity for the researcher to be open and discovery oriented. Another typical advantage of direct observation is the opportunity to see things that may normally escape the cognizant awareness of the participants, which allowed the researcher an opportunity to compare observations to perspectives from participants. Sometimes a researcher can learn about things that families may be apprehensive about talking about in an interview. Through direct observation, the researcher gained access to direct experience and personal knowledge as resources in understanding and interpreting the families’ approach to coping with chronic hypertensive cardiovascular disease.

During the observations, the researcher wrote notes on note pads describing the interaction between family members. The researcher also observed the families’ verbal and non-verbal communications. The researcher did this by grasping what each participant did, said, how, when, and to whom. Personal insights and reactions were documented as well as the setting of the home. The researcher asked the families to
partake in their normal daily routines, as if the researcher were not there. This process was done for approximately 30 minutes prior to the interview and during and after the interview.

**Written Documents**

The analysis of documents in qualitative research yields passages for clinical, organizational, or program records, publications, reports, personal diaries, memos, newsletters, statement of philosophy, policy documents, and quotations or excerpts (Bogdan & Biklen, 1992). An effort to review documents pertaining to hypertension and the physician’s practices was made to increase understanding and knowledge about the medical practice for the purpose of this study. Access to any routine or public records on patients was requested from the doctors and families for the study with consent from the patient. Three prominent publications, Circulation, which is a clinical journal, Circulation Research, which is a basic science journal, and Hypertension Journal were used in this study. These journals are published by the American Heart Association.

**Procedure for Data Collection**

Permission was obtained from the Human Subjects Committee at Florida State University to conduct the stated study (See Appendix E). The research proposal was then presented to internal medicine/cardiologists in order to gain assistance to recruit participants for the study at the practice setting. The prospective participants were contacted initially by the person designated (e.g., nurse) by the internal medicine/cardiologist, requesting permission to give the researcher permission to conduct an interview and review medical records (See Appendix F). The researcher then telephoned the prospective participants who consented to participate in the study (See Appendix G). A time was set up that was conducive for the participant. Upon the initial meeting with each participant, the researcher explained again the nature of the meeting, the purpose of the study, and the importance for the collection of data. Participants were informed again of confidentially regarding data collected by the researcher. Participants
were also given a written consent form to sign (See Appendix H), along with a questionnaire that asked for demographic background information, living arrangements (e.g., relative to the family), support contacts outside the family, and coping strategies and techniques practiced by the patients as well as other support systems. The researcher then collected the questionnaires that the participants consented to fill out.

Each interview was conducted in the participant’s home to promote safety and a familiar environment. It also provided an opportunity to observe the interaction between participants’ and other family members. Interviews were conducted in a professional yet friendly manner to gain a positive rapport.

Participants were asked prior to the interview for permission to be recorded or audio taped. This ensured that data was accurate and complete for later analysis and also provided the researcher and opportunity to observe the participant more in the interview process. The interviews of each individual ranged from 58 minutes to more than two and a half hours. The average interview took about one hour and a half. Observational notes were made as well of the participants’ reactions (e.g., frowning, smiling, and laughing) to specific questions.

**Method of Triangulation**

A second interview meeting occurred to review and discuss the initial transcript with participants. They all agreed that the transcribed interviews were correct. The observations and interviews added to triangulation of the data. These interviews lasted an average of 45 minutes.

A phenomenological avenue to qualitative research depends heavily on the subjective views of participants. Participants were informed that the tape recording of the interviews was solely for the transcribing of collecting verbatim information and that they would be destroyed after the study was completed. The audiotapes are kept in a secured locked filing cabinet. The written data is secured in a separate file. A transcriber was hired to do the transcribing and was informed of the importance of maintaining confidentiality of the participants and the content of the data. Also, names of the participants were replaced with pseudonyms and other identifying information was changed during transcription and publication of results.
Data Analysis

Data collected during observations and interviews was transcribed and coded. The transcriptions were copied onto a diskette and saved in Microsoft Word Document files. The researcher read the transcripts in their entirety several times trying to get a sense of the interviews as a whole before separating them into parts. The researcher then accessed the content of each question answered by the patient as well as the primary caregiver. Data collected was coded according to evolving themes and categories, health beliefs, and social support family interactions (Miles & Huberman, 1994).

Data analysis, consisting of the interview with the sample of five families, engaged a qualitative approach to reporting descriptively the results of the data. The analytical process included arranging the field notes of observation, the interview transcripts, and written documents for presentation. The data (observations and interviews) were presented and analyzed first by each question/category as a way of understanding what type of impact chronic hypertensive cardiovascular disease has had on each selected African American patient and each caregiver; what type of coping patterns have been exhibited by these families; what adjustments were made in lifestyles; and whether or not the family has played a significant role in terms of the patient coping with the disease.

Next, data and findings were compared and contrasted between each patient and the caregiver dyad and the patient group and the caregiver group to identify similarities and differences. For example, once data was analyzed for each interview question, the interviews were analyzed with other appropriate qualitative strategies such as identifying over-arching themes and considering metaphorical themes in the phenomenological grounded theory tradition (See Table I). Data was then organized and interpreted in the light of concepts from phenomenological, social support (See Table II), and health belief theoretical perspectives.
<table>
<thead>
<tr>
<th>INTERVIEW QUESTION CATEGORY</th>
<th>THEMES</th>
<th>EXAMPLES</th>
<th>HOW IMPORTANT</th>
<th>PATIENT'S QUOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOW FAMILIAR ARE YOU WITH CHCD?</strong></td>
<td>FAMILIARITY: KNOW WHAT CONDITIONS THE DISEASE CAN CAUSE &amp; FAMILY BACKGROUND</td>
<td>HEART ATTACKS &amp; STROKES GENETICS</td>
<td>VERY IMPORTANT</td>
<td>“IT CAN CAUSE HEART ATTACKS &amp; STROKES”</td>
</tr>
<tr>
<td><strong>HOW HAS THE DISEASE AFFECTED LIFESTYLE (in general)?</strong></td>
<td>FEAR OF THE DISEASE</td>
<td>DON’T DO THINGS THEY USED TO DO</td>
<td>EXTREMELY IMPORTANT</td>
<td>“AFRAID TO MAKE LOVE TO MY HUSBAND”</td>
</tr>
<tr>
<td><strong>WHAT PROBLEMS ARE THE MOST CHALLENGING AND EASIEST TO COPE WITH?</strong></td>
<td>NEED FOR FAMILY SUPPORT &amp; SPIRITUALLY</td>
<td>DIET GOING TO THE DOCTOR</td>
<td>EXTREMELY IMPORTANT</td>
<td>“NOT EATING SALT” “KEEPING MY APPOINTMENTS”</td>
</tr>
<tr>
<td><strong>ARE THERE OUTSIDE AGENCIES THAT HELP?</strong></td>
<td>NEED FOR EXTERNAL SUPPORT</td>
<td>S.H.I.N.E. BIG BEND TRANSIT</td>
<td>EXTREMELY IMPORTANT</td>
<td>“THE CHURCH” “SPEECH &amp; PHYSICAL THERAPY”</td>
</tr>
<tr>
<td><strong>WHAT COULD MAKE THE CIRCUMSTANCES BETTER?</strong></td>
<td>DEPENDENCY ON THE PHYSICIAN</td>
<td>CHECK-UPS</td>
<td>EXTREMELY IMPORTANT</td>
<td>“TAKING MEDICATION &amp; DOING WHAT THE DR. SAYS”</td>
</tr>
<tr>
<td>TYPE OF SUPPORT SYSTEM</td>
<td>PATIENT</td>
<td>PRIMARY CARE PROVIDER</td>
<td></td>
<td></td>
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<tr>
<td>------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>EMOTIONAL</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSICAL</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INSTRUMENTAL</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 4

ANALYSIS/RESULTS

The purpose of this study was to comprehend how African Americans and their families cope with chronic hypertensive cardiovascular disease. Data collected through observations, questionnaires, and interviews are presented and analyzed in this chapter. The over-arching themes that emerged from the data include: fear and anxiety of the disease; dependency on the physician; family background and familiarity; need for family support; need for external support; coping strategies and techniques; socioeconomic status; and spirituality. Each will be further detailed and exemplified with quotations from participants.

Sample Description

To be eligible for recruitment in the research, patients had to be diagnosed with hypertension for at least a year and African Americans between the ages of 40 and 85. The other participants served as the primary caregiver for a family member who has had hypertension for at least a year. The use of a purposive convenience sample is the most common method of sampling for research such as this.

When research is being conducted on chronic illness, convenience samples can be acquired in a number of ways including those which are obtained from rosters in self-help groups, those that are clinically derived, or referred by medical practitioners. A sample of five families included two male patients with the primary caregiver being female, and three female patients with two of their primary caregivers being females and the other male. All the participants resided in North Florida. The ages of the participants ranged
from 40 to 85 as shown in Figure 3. One of the patients worked and three caregivers worked. One patient received a GED and one caregiver holds a Ph.D. (See Table III for further details).

Figure 3: Age of Participants
Coding & Analysis Procedures

The five patient interviews, as well as interviews of their primary caregivers, were tape recorded. Audiotapes for each of the families were transcribed verbatim. Poor grammar, incomplete thoughts, peculiar phases, and other components of the spoken word bring to light how the participants’ think and talk about specific issues and so remain in their unedited version. Although editing may improve readability of transcripts, too much editing and cleaning up of transcripts is considered “undesirable” since “it tends to censor ideas and information” (Stewart & Shamdasani, 1998, p. 514). During those instances when participants cut off in the middle of a conversation, dashes (--) are used to signal this circumstance. It should also be noted that some quotations in this manuscript have been edited for brevity and ease of reading.

During the analysis of data, each transcript was examined individually to identify core themes or concepts that emerged. Data analysis in qualitative research is not a linear but an iterative process (Zyzanski, S., McWhinney, I., Black, R., Crabtree, B., Miller, W., 1992). In view of the fact that the primary aim of content analysis is to uncover themes, the first step in coding the individual interviews was to examine the obvious themes as determined by the sameness; in essence a template analysis style, advocated by Crabtree and Miller (1992). Data was broken down into distinct parts, studied, closely examined for similarities and differences, and questions were posed about the phenomenon of interest, (i.e., coping strategies and techniques) as reflected in the data.

Through this course of action, my findings and assumptions from individual interviews were explored. The findings from observations, questionnaires, and individual interviews in this research are presented in the following section. Numbers were used in the form of a code for each household and each participant to shield their identity (See Table III). In addition, pseudonyms were given to protect the confidentially of the participants.
<table>
<thead>
<tr>
<th>Household Code</th>
<th>Age</th>
<th>Marital Status</th>
<th>Employment Status</th>
<th>Grade Level Completed</th>
<th>Living in Household</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-P</td>
<td>50</td>
<td>M</td>
<td>Y</td>
<td>A. A. DEGREE</td>
<td>3</td>
<td>Between $30,001-$40,000</td>
</tr>
<tr>
<td>01-C</td>
<td>66</td>
<td>M</td>
<td>Y</td>
<td>A. A. DEGREE</td>
<td>3</td>
<td>Between $30,001-$40,000</td>
</tr>
<tr>
<td>02-P</td>
<td>67</td>
<td>S</td>
<td>N</td>
<td>B.S.</td>
<td>1</td>
<td>$12,000</td>
</tr>
<tr>
<td>02-C</td>
<td>69</td>
<td>D</td>
<td>Y</td>
<td>HOLDER OF DOCTORATE DEGREE</td>
<td>1</td>
<td>$80,000</td>
</tr>
<tr>
<td>03-P</td>
<td>40</td>
<td>S</td>
<td>N</td>
<td>NINTH (RECEIVED GED)</td>
<td>1</td>
<td>$7,200</td>
</tr>
<tr>
<td>03-C</td>
<td>58</td>
<td>M</td>
<td>Y</td>
<td>TWELTH</td>
<td>2</td>
<td>$30,000</td>
</tr>
<tr>
<td>04-P</td>
<td>64</td>
<td>W</td>
<td>N</td>
<td>ELEVENTH</td>
<td>1</td>
<td>$6,540</td>
</tr>
<tr>
<td>04-C</td>
<td>42</td>
<td>M</td>
<td>Y</td>
<td>ELEVENTH</td>
<td>3</td>
<td>Between $20,001-$30,000</td>
</tr>
<tr>
<td>05-P</td>
<td>82</td>
<td>M</td>
<td>N</td>
<td>SIXTH</td>
<td>3</td>
<td>Between $10,001-$20,000</td>
</tr>
<tr>
<td>05-C</td>
<td>69</td>
<td>M</td>
<td>N</td>
<td>SIXTH</td>
<td>3</td>
<td>Between $10,001-$20,000</td>
</tr>
</tbody>
</table>

CODES:
Household Codes:
Patient (P); Caregiver (C)

Marital Status:
Married (M); Single (S); Divorced (D); Widowed (W)

Employment: Working (Y) Not working (N)
Findings

The Participant’s Households

Descriptions of each household and participant are provided because participants must be considered in their contexts. The description will lend insight into the findings.

The Red Family

The Red Family consisted of a mother, Ruby (01-P), a patient in her early fifties, a step-father (01-C) Rudy, her caregiver in his mid-sixties, and a son, Rhett (01-2S), seventeen attending high school. The mother has two other children, a daughter Rose (01-D) in her late twenties, and an older son Ryan (01-1S) in his early twenties who live in other parts of the city. The mother and stepfather are holders of an Associate of Arts degree. The mother is a full-time nursing assistant/medical technician and the stepfather is employed as an environmental technician at a local hospital.

The Red Family lives in a two-bedroom apartment in the heart of the city. I was invited to sit in the living room to conduct the interview. The room was filled with family pictures on the walls and a coffee table along with a Bible. A huge stuffed animal that had been won at a fair covered part of the living room floor. There were two sofas that marked the area of the living room. The dining table defined the dining room area. A television was playing in one of the two back bedrooms. The apartment had a very homey atmosphere. The mother checked on the stepfather periodically as he laid in bed in one of the back bedrooms watching a ball game. Initially, the husband and wife were interviewed separately. Ruby Red began by telling me the following:

I had my first stroke when I was forty-five and my second when I was forty-eight. With the first one, I had a little tingling in my head and a little dizziness. I was at Publix on Pensacola Street. Someone said “Mam, you alright?” I told them I was alright just felt a lil dizzy. They called my family. And sho nuff, it was a stroke. Not no TIA [Transient Ischemic Attack].

The second time, I had worked on August 4, 2000, on my job and I came
home to just relax, you know, for 30 minutes, and I went to sleep………woke up 15 minutes later and I said I’m going to the bathroom….got up and sat side of the bed, went to get up to walk and could not use my left side. I told my son to call the paramedics he said “oh momma, you’re alright. But he called them and they came and there it was. Sometimes people don’t make it through strokes and sometimes they do. It just all depends. It just so happen I caught it in time. When they came my pressure was 180/120. It was not a TIA you hear me, it was a stroke!

Mr. Rudy Red expressed some deep seated concerns that he had regarding his wife’s illness. He stated that he is not as knowledgeable as he would like to be, and that he knows that he does not know as much as he should about it, but that he hopes doctors can enlighten him as well as his wife on what is the culprit regarding this disease:

I’m hoping that they can find the root of the problem, or what brings about these what she calls TIAs or whatever that is. I don’t think she’ll ever be herself again, not 100 percent.

This disease is very serious. I hope that they can do something about it. It has not really affected my work. You know, she goes to work and I go to work. You know, since I don’t have the disease, it hasn’t affected me as much as her. It has in a sense, mentally, but not as physically.

The Blue Family

The Blue Family consisted of Baby Blue (02-P), a patient who is in her late-sixties. She has an Associate of Arts degree and used to work for a public service organization. She lives alone in a senior citizen building on one of the highest floors. The apartment is the size of an efficiency with everything in one room with the exception of the bathroom. The walls are covered with artifacts from Africa. There is a sofa and loveseat on two adjoining walls. There is a huge window that allows you to have a
magnificent view of the city. A large floor model television that does not work covers another wall. A medium size television sits on a stand in front of her dresser. Family pictures, jewelry, and whatnots covered her dresser. The room was carpeted and the dining room table with two chairs was covered with medicine, cigarettes, eyeshades, and mail. She made excuses for her untidiness. I assured her that everything was fine. She then began telling me things that she has to cope with regarding the hypertension:

I can’t walk like I use to. My circulation is cut off because of my lifestyle; I’m going to tell it like it is. I’ve had friends die of that. Smoking will do that much damage. Your circulation, I think that’s where my hypertension may be came up at, because I never had it. I can’t hardly walk. I have to sit. Especially pulling a hill. It’s painful for me to sleep at night. It’s just difficult. I’m in a lot of pain all the time. My doctor says I have peripheral vascular disease. I’m getting ready to go to pain management to get some more shots just to be able to walk…..for my circulation. Smoking, drinking, that’s when the hypertension come in there, it’s very chronic.

My doctor asked me about two weeks ago if I had eaten any pork. I said “no sir.” Then it dawned on me, I had been eating pork skins, just for a snack,…that was too much. He told me NO MORE PORK! And I know it, but I love it. I was suppose to have surgery on my eyes, but my pressure was up so they couldn’t operate on my cataracts. I’ve been told that I’m stubborn. I’ve been told fifteen years to stop smoking, it’s killing me. My circulation is cut off. Anything, air condition, my legs start a tingling just like somebody is sticking a needle in me. It aches so bad. I even wear long johns in the summer time. The disease apprehends me, shopping, anything with air conditioning. I am just bombarded. My whole body.

Baby Blue has a sister, Sapphire (02-C), who does not live with her but serves as a strong family support system for her. Baby Blue says “you could say that my sister is my primary care provider.” Sapphire also is in her late-sixties and lives alone. She is divorced. She is the holder of a Doctor of Philosophy degree. She works full-time as a
professor at a local university. Sapphire’s home is immaculate. Everything has a place. As you walk into the foyer, you are confronted with cathedral ceilings and two huge pillar walls. She lives with her dog Atari. There are artifacts on the walls, shelves, and mantles from her travels to Indonesia, Africa, Asia, Europe, and the Caribbean. Sapphire asked me if I would like anything to drink. She talked with me as well as her dog, who I can tell is the king of the house. In between conversation with Atari, Sapphire stated the following:

Even though I’m my sister’s care provider, I too have hypertension. It runs in the family, and I know what abnormalities can come about. We have a sister, a younger sister, who has had one of her legs amputated. I take my medication religiously girlfriend; and I’m constantly on her about being diligent in taking hers. I just don’t know what I’m going to do with her.

The disease has affected my lifestyle only in the sense that I do take medication on a daily basis, other than that, well I don’t know, I think a few years ago I had a mini stroke, and I was not knowledgeable about it, and the only reason I found out about it was because I had stars running in front of my eyes and when I went to the doctor, he presumed that I had had a mini stroke.

The disease has not affected my work. I’ve never stopped or been ill because of it. It has not affected my lifestyle other than the inconvenience of taking the medicine. Since I work I have more free time on the weekend, but I would not say that the weekend is a better time for me to provide care, because I’m there whenever my sister needs me.

The Yellow Family

The Yellow Family is comprised of Yardley Yellow (03-P), a patient who is in his early forties. He has never been married and lives alone. He received his GED when he was in his twenties. He does not work, and has never worked due to a disability. Several plants, a water hose, and a piece of furniture (i.e., a credenza) covered Yardley’s front
porch. Upon walking into the home, I was greeted by dim lighting and a voice coming from the television that is covered with photos of family members and sits on a stand made out of milk crates. In his living room sits an electric scooter that his uncle willed to him. It is very special to him, since his uncle previously used it. Yardley tells me that he owns two electric scooters and two manual wheelchairs. There are pictures on his wall of family members and famous baseball players. Yardley loves baseball very much and he collects baseball cards. There are several photo albums and cases (one shaped like a baseball) of baseball cards. He says that he would love to sell some, but people just want you to give them something. No one wants to pay for anything.

On Yardley’s coffee table sits a pair of sunshades, VCR tapes, medicine, bills, diskettes, a hair brush, a jar of pennies, a fly swatter, and a pair of scissors. On his dining room table is a can of roach spray, a flashlight, and a calculator. He also uses it to house his computer and printer. There is a baseball calendar on a closet door that faces the sofa. Yardley lives in a one bedroom, living room/dining room combination housing unit. It is not an efficiency apartment he informs me, and it is not handicap equipped. He says he does okay and feels safe alone because his telephone is programmed for emergencies and he has two emergency switches in his home.

Yardley is a middle child who has no offspring. He has an older sister who has two children, and a younger sister who has one child. He is interested, but does not have a wife, girlfriend, or any prospects. Yardley begins to tell me about how he feels in relation to his disease:

You know, I have lived with this disease for a long time now, and I think I do pretty well. I have enough emotional, physical, and instrumental support. My doctor is good, but you have to wait too long. I’m thinking about changing. I can’t stand to wait.

Yardley Yellow’s mother, Yolanda Yellow (03-C), serves as his primary caregiver. Yolanda lives about a mile away with Yardley’s father Yale (03-F). She graduated from high school and works at Associate Land and Title. Yolanda is in her late fifties, but doesn’t look a day over forty-five. She has several plants in her living room, most of them plastic. One of them she says she has had for 35 years; it’s from her
mother’s funeral. She keeps it on top of her television as a reminder. On the stereo sit pictures of grandchildren. Her coffee table holds a two and a half foot Bible (it’s almost the same height as the coffee table). Her end tables hold lamps that sit on doilies surrounded by magazines. A picture of Jesus hangs on one wall. On another wall hangs a large picture of the Last Supper. Huge ceramic dogs and cats surround the living room. A curio houses little ceramic what-nots. Yolanda Yellow says she had to purchase that piece of furniture to protect her things or “kill those grandchildren”. The dining room table is forty-five years old according to Mrs. Yellow. She says that she can still see Yardley walking under it. She opens up and shares some personal things:

Child, let me tell you something. I worry about my baby, but I don’t let him know. I just wish there was something I could do for him. He’s my baby, you know. I try and be there for him, but I feel so helpless sometimes. You know he can’t walk. If I could I would give him my legs.

I don’t know if you know, but I am the one who does everything for him. Not his father, or sisters, me. And I want you to know, I don’t mind one bit. I wish he would come and live with us, but he’s so independent. Doesn’t want to live with his momma and daddy, you know. Thinks that maybe one day he’ll meet someone. God bless his soul. I really don’t think he is going to meet anybody that wants to take care of, girl I’m just rattling off. My husband says I talk too much.

Yale Yellow, Yardley’s father yells from one of the back three bedrooms, “Woman, when you gone brang me my dinner?” Ms. Yellow asks me if I’d like to stay for dinner. She says that no one can fix peas and okra like she does. We sat down at that 45 year old table and ate smothered steak, rice, rolls, garden salad, and the best peas and okra I’ve ever had and drank sweet tea. For dessert we had sweet potatoe pie topped with Bryers vanilla ice-cream.

There was not much interaction going on between family other than when Mrs. Yellow took Mr. Yellow his dinner. I could not detect the attitude nor the non-verbal communication of Yale Yellow and Yolanda Yellow, since I never did see him. The only
verbal communication that I heard was when he asked for his dinner.

The Green Family

Gretchen Green (04-P), a patient, was cleaning off the stove when I arrived. She had cooked and was just tidying up she said. The apartment was very hot, and I was very uncomfortable. I did not comment due to the fact that I did not know the full extent of her medical condition, nor was I aware of her financial situation. But surely I thought that she could have opened a window or the front door since there was a screened door as well. Gretchen lives in an area that is known for crime (drugs, shootings, robberies, etc.) so maybe that is the reason for her house being locked down. However, my primary concern was Gretchen being in a safe, comfortable, and familiar environment so that she would respond openly and in detail, providing rich and in-depth data during the interview. Needless to say, after about 40 minutes I adjusted to the climate. Lighting was dim, but she did ask after she saw me straining if I wanted her to turn on another light.

Gretchen was dressed in a floral house dress and bedroom slippers. The house was very neat. A green chair sat on the wall right next to the entrance, and an orange chair with a light green towel over the back sat diagonally across. Pictures of family members and dolls covered the floor model television. A floral sofa and loveseat covered the other walls in the living room. Family pictures covered every wall. The coffee table was decorated with a crystal fruit bowl and three candy dishes. An etigere’ held pictures of family, huge ceramic angels, and a black ceramic Jesus. The dining room had a wooden china cabinet, a small deep freezer, and a dining table for four. Upon the dining room table sat a glass cake holder.

Gretchen tells me that she has to have everything in place. She says that things might be dusty, but they have to be in place (as the television is playing softly in one of the two bedrooms in her home). She says that she had seven children, four boys and three girls. One son died of cancer, and all of the six living children have high blood pressure. Gretchen is 64 years of age and widowed. She completed eleven years of schooling and worked for a while babysitting. She had to stop due to a disability. Her monthly income is $545. She was very eager to talk. She began by saying
I have the disease you know. But I don’t know if the medication works or not. I have gone for three days without taking it, and I still felt fine. So that’s why I don’t know if they know what they’re talking about. I take my medicine though, cause they tell me I need to. But, hell I don’t know. I just do what the doctor says. I do know though that I was born with a horse shoe kidney and I have problems urinating sometimes, but I don’t wear depends.

Gretchen lives alone, but her daughter Gwenneth, (04-D) serves as her primary caregiver. Gwenneth lives across town in a three-bedroom house with her husband and 20-year old son. The furniture in the living room was covered in plastic. A few religious pictures of Jesus and The Last Supper hung on the walls. A religious figure of Jesus sat in the center of the coffee table. A television was enclosed in the center of a wall unit. Below was a complete surround sound system that encompassed a CD player, turn table, radio, equalizer, cassette player, VCR, and two speakers. Above the television set were shelves that housed quite a few videos and CDs. In one corner of the dining room a curio displayed religious figures (e.g., a praying hand, and a Black Jesus on a cross). In another corner was an artificial plant. Gwenneth is forty-two and completed the llth grade like her mother. She works full-time during the summer and part-time all other seasons taking care of children. Her family’s annual income is between $20,001 and $30,000. Her conversation began with the following:

I want to know if anything can be done about the situation. My mom has been on medication forever and they can’t seem to do anything right. I don’t believe they know what they are doing. She has burns on her arms now from the patches [high blood pressure] and they didn’t work. Then they tried her on this other medication and it didn’t work cause it made her hallucinate. You know, so…..

I hope this paper you are trying to write can help with the problems, especially getting some aide.
The Orange Family

The Orange Family is comprised of a father Orin (05-P), a patient who is in his early eighties, a mother Olga (05-C) who serves as the primary caregiver (in her late sixties), and a daughter, Orchid (05-D), nineteen and attending college. There also is a son (05-S), Omega, who is in his late fifties and lives in the same city. Orin and his wife Olga both completed the sixth grade. Orin worked as an equipment operator until the age of 65, and Olga worked as a cook for the Governor of Florida but had to quit after several years due to a disability. Their total annual income ranges between $10,001 to $20,000. Orin, Olga, and Orchid Orange live in a yellow brick home with a screened in front porch. The house is surrounded by a locked gate, where a Doberman keeps watch. I had to call Olga on my cellular phone so that she could escort me in the house. As I entered, I was greeted by Orin as the television played in the background. Orin had been watching the news as he sat in a chair next to the sofa. A beautiful picture of Orin and Olga hung on the wall. The television sat on a piece of furniture in the living room. A sofa sat next to the wall on the south side of the living room where a floor heater laid next to it. A serene picture of a lake surrounded by trees hung over the back of the sofa. A love seat covers the west wall of the living room. A chair and ottoman sat next to the wall near the front door. On the coffee table lay a portable phone receiver, a candy dish, inhaler, comb, brush, and handkerchief. The dining room displayed a monument of pictures. There were family pictures on top and inside the china cabinet. There were family pictures on the walls, on bookshelves, and near the computer that sat on a computer stand, of children, grand children, and great grand children. Orin began the conversation with the following:

I don’t know if she [Olga] told you, but I also walk and ride my bicycle that sits on my porch two miles a day. I feel good and I’m in good shape to be an old man. Just look at me. How old do you think I am? And I bet you can’t guess how old she is [Olga]. She’s thirteen years younger than me. How about that!
Summary

The impression was given that all the families were eager to talk about how the disease (i.e., chronic hypertensive cardiovascular disease) has affected their lifestyles. The environments were different, some patients lived alone, some did not, but a similarity was that they all possessed some form of spirituality whether it is in the form of pictures, paraphernalia, or other artifacts. Other similarities were the prevalence of family support, even though loved ones (family) may not have lived in the same household, and pictures of immediate as well as extended family members in every home. In addition, all households of the patients were low-income. Although one home was untidy, the majority were clean, and all but one of the homes suffered from a shortage of space.

Definition of Themes

Eight major themes emerged from the language of the participants and developed from the analytical codes. The eight major themes will be covered in depth in the following sections.

Fears and Anxiety of Disease

This theme described the patients’ fears of what the disease can do to them and what the disease can cause them to do to others. Human beings portray symptoms that are committed to memory and recalled in future incidences. Because hypertension can be “symptomless” and in many instances untreated, patients often lose efficiency in the functioning of organ systems, the patient is often left with thoughts of how the future is to be lived. Thus, fears existed in these patients’ minds relative to outcome, lifestyle changes, and above all consequences of the disease such as stroke, kidney failure, and heart failure. These fears worked in both positive and negative directions since patients often created scenarios as to how the feared conditions could be handled.

Fears of the disease in itself was a complicated issue. Input from other sources (e.g., other patients, friends, reading materials, family, and others) seemed to cause these patients to feel vulnerable. This was even more problematic for the individual who was non compliant with treatment procedures or the ones who were under educated about the
disease. So, within the context of this study, the patient’s fears spilled over into attitudes towards coping and may be part of the intricate relationships the patients’ can use to adjust to everyday conditions and activities.

Caregivers were plagued with the fear and anxiety of their loved ones having complications of the disease. In other words, they feared them having strokes, heart attacks, kidney failure, going blind, and suffering from peripheral vascular disease (e.g., losing their legs) just to name a few.

**Patient fears and anxiety.** The patients were asked to tell how the disease affected their lifestyles (how has their life changed). Some of them expressed their fear of physical harm:

**Ms. Ruby Red 01-P:** I had two different strokes. The first was called *hemorrhage of the brain* and the second was called a *blood clot*. Both dealt with the left side. The medicine is helping the hypertension, but it can’t help what the stroke has done. I was not on medication when I had the first stroke, and I didn’t listen to my doctor after the first stroke. But girl, I takes my medication very faithfully now. Cause I know…..first hand what it can do. This disease has affected my vision, hearing, listening, and concentration.

**Ms. Baby Blue 02-P:** Well, I don’t work, so I don’t have to worry about it affecting my work. But on a personal note, I know that I should not smoke. I’m afraid because my doctor told me if I didn’t stop the smokes that within ten years, if a blood clot worms, my legs will be amputated. And it happened to my baby sister and she begs me to stop and I know that it’s painful, I can hear it in her voice. She fears for me; she begs me to stop and I know she is telling me only because she loves me.

**Mr. Yardley Yellow 03-P:** My lifestyle has changed a lot from this disease. I know that I have to take my medication everyday and not skip a beat. This is a very, very, serious thing. It will kill you. And I know that I CANNOT let things upset me. You know stress will kill you too. I don’t play with my life
so I do what I’m suppose to.

Ms. Gretchen Green 04-P: Well, let me see, let me see, ……my life has changed a lot, cause I don’t go out like I use to. That’s because I’m scared of falling, getting dizzy. Not too long ago I had, well the doctor said I had cong…heart attack, [congestive heart failure] and that come from high blood pressure. I’m kind of scared going out too cause I kind of feels it coming back, you know. One time I passed out and I was by myself. I swells up too.

In describing the events that indicated fears and anxiety of disease, they indicated several other sub-themes related to fear. One was fear of hurting or burdening others as well as family:

Ms. Ruby Red 01-P: It affected my family a lot. You know, I found out I had hypertension after the birth of my last child. I don’t do the things……such as playing sports, driving, going to uh different music programs, I’m just afraid that the stroke is going to come on again you know? Interrupted by the phone ringing Girl……I mean Ms. Lady, you just don’t know. I don’t know what to do. My son, the one who lives with me, he doesn’t want to be bothered sometimes, I think I embarrass him. It’s hard on them, it’s a burden.

After Ruby Red described suffering several close calls and several strokes, another sub-theme that arose was a fear of the patient’s personal ability to do their work. The patient was also fearful that she may cause bodily harm to someone:

Ms. Ruby Red 01-P: You know, I’m a medical technician, and sometimes I can’t go to work because I’m afraid that I might do the wrong thing you know? Sometimes my mind has me so messed up. I get light headed and feel dizzy, and girl I just call Dr. Bryce Chandler and tell him what’s going on, and he tells me to just take care of myself and don’t worry about coming to work. Like I said, I’m able to work some, but it’s kind of hard. My mind

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isn’t as sharp as it use to be. It has affected my ability to think.

I don’t drive anymore, it doesn’t mean that I can’t drive or don’t want to drive, I just don’t want to hurt somebody, kill somebody, so it’s best not to drive. That’s what’s set in my mind. The fear you know?

Another sub-theme that became prevalent was a fear of the patient being able to have the same type of personal life:

Ms. Ruby Red 01-P: I’m a married woman, and I don’t have the sexual desire anymore; I’m afraid I might have another stroke if I get too excited and I’m scared to drive again; I’m just scared to do anything,….think a stroke is going to come on, you know? And even at church………..like when the preacher is preaching. I’m afraid that if I get happy it might come on. I’m just a homebound person now.

I cannot eat what I want. I’m restricted to a certain diet now. I eat vegetables, drink more juices and I take vitamins cause I don’t have the energy like I use to have. I don’t eat pork because the pork is a hypertension food. I eat chicken, fish, and turkey only when I eat meat. It’s a terrible disease to have.

The stroke affected my left side. I can’t walk for a long period of time without the left side hurting. It affected my speech. I don’t talk as plainly as I use to talk because my mouth is twisted, and when you have a twisted mouth your words don’t come as plainly as usual.

Mr. Orin Orange 05-P: I know that there are some things that will cause it [high blood pressure] so I try to stay away from those things like pork, salt, and collard greens. See, I’ve had double by-pass surgery and I know what it [high blood pressure] can do. I was 75 years old when I had it, but through
the grace of God I made it through.

It slowed me down a whole lot. You know I’ve had it a long time and now I have to take pills for the rest of my life. Won’t try and do some of the things I use to do. I won’t smoke or chew tobacco. It didn’t affect my work too much. Like I told my doctor, I might not be able to do some of the things I use to do [sex] before I got this disease, but I’m just trying to live.

An interesting and unexpected sub-theme was that fear and anxiety brought on by chronic hypertensive cardiovascular disease brings out past fears:

Ms. Baby Blue-02-P: You want to hear this? I’m gonna tell it like it is. I know I should stop, and I’m afraid of what’s going to happen if I don’t……….but you want to know ………you want to know. You know what it’s like to be raped? Well, I’ve been there. It hurts my body. I take a drink or a smoke to try to forget………NOW THAT’S THE DAMN TRUTH AND I’M THROUGH WITH IT! She begins to cry.

I got pregnant from that rape and I had an abortion, and back then they were not legal. I’ve paid the price. I’m in my sixties and I will never have a child; they butchered my body. Oh, God! She cries unmercifully. Then she takes a drink.

Caregiver fears and anxiety. The caregivers were also asked to tell how the disease affected their lifestyles (how their lives changed). One of them expressed fear of losing their loved one:

Ms. Gwenneth Green 04-C: I’m afraid for my mom, cause I don’t want to loose her. She’s so fragile. I wish they could get her medication strait. When she was taking some of the medication, it kind of affected the kidney…threw her off balance, she had to go into the hospital. A lot of things happened. Well she had memory lost, for a while she wasn’t
responding. She didn’t know where she was, she couldn’t take care of herself really, just like a person had lost their mind. (Mother interjects that daughter just couldn’t wait to say that). It was a pretty rough time. Also the medication affected the liver. Also caused congestive heart failure.

Another sub-theme that became prevalent was a fear of the caregiver not being able to have the same type of personal/normal life:

**Rudy Red 02-C**: Because my wife and I know how serious this disease is, we have had to alter our eating habits. She more so than me, but nevertheless, all of us. It is nothing to play with.

My wife comes home from work complaining about headaches. I can’t go and hang out with the fellows like I use to, I had to alter my personal life. She’s not as lively as she use to be. It has affected her speech. Her speech is slurred. She’s fatigued all the time. She’s totally not herself like before. Once she gets home she doesn’t want to go anywhere, that’s scary you know. I wish I knew more about the disease, that’s what frightens me.

**Mrs. Yolanda Yellow 03-C**: Well, I have to tell you. I thought my husband was going to die after that second heart attack. Baby, I was sooooo afraid. I just kept praying and praying, and you know, God answers prayers. He made it through. You know my husband is so stubborn. I think I am more afraid of the consequences that he is. Can you believe he is still smoking. See he has made it through two heart attacks, so I guess he thinks he can’t die. But Lord knows he is going to mess around here and hey….that’s goin to be it. He is crazy. I just pray for him.

I would say that this disease has affected my life by me having to constantly tell that man to take his medicine. I have to stay on top of things caus he ain’t keeping up. Now my baby, he takes his medication. I really don’t have
to remind him. He is so independent you know. I just go get him on the weekends cause he won’t move in with me and his dad, says he wants to live on his own. So the weekends give me more time with him cause he’s here, and you know I work so I have to be here with his hard headed daddy.

Ms. Olga Orange 05-C: I take my medicine. I know that it can cause a heart attack, stroke, and for some people impotence. I had a heart attack when I was 42 years old. I take my medicine.

I’m watching what I eat, and watching my weight. Like I said it causes impotence in some people, but it hasn’t did it, you know it hasn’t changed my life. I told you how I’m dieting, cause when I first found out, I was weighing 269, now I weigh 232. The disease has not affected my lifestyle that much. That’s the amazing grace of God. I keep going because he knows people need me. I still go to church, fishing, grocery shopping.

I have to do more for my husband, and God provides me the strength to do it. He [God ] knows people need me.

The weekend is not necessarily a better period for me to provide care for my husband, anytime is good cause I don’t work.

Dependency on the Physician

This theme involved the trust that the participants had in their physician. A patient’s belief system about his/her disease can be based on the relationship with a physician. The physician’s role in this interaction is often two-fold; the providing of remedial intervention through medications, and the providing of advice through patient education. The patient can become very dependent on the physician for both of these areas of interaction. Thus, the type of care and education provided to the hypertensive patient were thought to contribute to outcome and life expectations. The extent of
patient-physician interaction may become one in which there are coping strategies established around the interaction because of complete trusted confidence in the physician. Even family members became a part of this and patient care success was hinged to the dependency.

Caregiver dependency on the physician relied heavily on a need for collaboration, communication, and mutual respect. The caregiver expected the physician to hear his/her needs as caregiver.

**Patient Dependency on the Physician.** When patients were asked what could be done to make the present circumstances better, they all emphasized the importance of listening to their physician’s advice regarding medicine and regular examinations. Listed below are some statements made by the patients:

Ms. Ruby Red 01-P: Do what your doctor says. Take your medicine. Don’t be like me. That’s why I had a second stroke. But you can believe this, I listen to every word he says. I believe in him and he takes care of me.

Ms. Baby Blue 02-P: Make sure you get check ups. Listen to your doctor. Don’t be like me. I want to, and I do, I just get so depressed and wallow in my sorrow. I try to forget what’s really going on with me, but I also don’t want to die.

Mr. Yardley Yellow 03-P: I take my medicine that my doctor prescribed daily.

Ms. Gretchen Green 04-P: I believe what my doctor says most of the time, but not all the time. Like I take my medicine, but sometimes it seems that it is not doing any good, you know. But I still believe him and does what he says.
Mr. Orin Orange 05-P: I believes in what my doctor says. I believe the medication helps so I take it. I also feel if something could be done for senior citizens to help with the cost of medication. When in the world are they going to do something to help us senior citizens with this medicine. Paying for that medicine is high and steady going up……although I try to take it, they say [doctor] I’ve got to have it, and I believe that. That’s why I take it, but it’s so expensive.

**Caregiver Dependency on the Physician.** A caregiver’s belief system about the disease of the patient was often based most times on the type of interaction the caregiver has with the patient as well as the physician. The physician provided advice through education and corrective intercession through medication. Listed below are expressed thoughts of the caregivers:

**Ms. Sapphire Blue 02-C:** Well, definitely get yearly or six-month examinations by a doctor. You definitely take the medication that’s prescribed, and if the prescription doesn’t seem to be working, follow through with the doctor to get a medication that’s working.

**Ms. Olga Orange 05-C:** I make sure he takes his medication and get to the doctor for his examinations and do what the doctor tells him. He’s pretty good about following the doctor’s advice. We both are.

I wish he could, was able to get out and go. He love to play checkers, but he hasn’t been able to play checkers in a while, you know that was his therapy. But until the doctor says so….well, we try to do what the doctor says because we believe in him.

In unfolding the actions that indicated dependency on the physician, trust and loyalty of patient to caregiver was another sub-theme that arose:
Mr. Rudy Red 01-C: I don’t know what the doctor said to her, but she keeps saying “I don’t want nobody cutting me in my head,” you know. And I don’t know what that’s all about. But when she goes back next week, I’m going to go with her. Her niece has been taking her. She does not want me to take her. I’m going to go and just ask the doctor a lot of things cause there are a lot of things I don’t know. And when she comes back and explains things to me it’s really confusing cause she just rattle off some things the doctor said this, the doctor said that and most of it I’m not understanding. I’d rather hear what the doctor say cause I don’t know if she is switching any of this or not. Or she may just be telling me so much; I’d rather hear it from him.

Family Background and Familiarity

This theme described the history of the patients’ family to determine if genetics played a role in the development of the disease. Decisions about lifestyle and the level of involvement in patient’s care was affected by patient’s family background. Not only was there a link to the patients’ susceptibility and outcome contained in the family history but any other information about life style and behavior patterns that contribute to coping. Most patients showed concern about the history because it may be an immediate source of contact as to how they respond to medications, disease repercussions or recovery potential. Equipped with this knowledge, through interpretations, may give hope to patients and render their coping techniques effective.

Familiarity with these concepts among those patients who continue or are involved in some form of higher education affects the course of their disease.

As expressed, patients demonstrated a need to hold on to members of their family during their illness. This is a form of dependency that can result in comfort and protection. This is manifested as a need and coping strategies may develop from or be inclusive of the need.

At times the caregiver was also hypertensive, and having to care for a loved one put an additional burden and added additional stress on the caregiver, causing the caregiver to be at greater risk for having a stroke or developing some of the same
complications as the patient. In addition, a caregiver should be familiar or have some knowledge (education) of the disease.

**Patients’ Family Background and Familiarity.** Several of the patients talked about how someone in the family other than themselves was plagued with hypertension, some more severely than others. The patients also discussed how familiar they were with the disease. Their responses are illustrated below:

**Ms. Ruby Red 01-P:** My sister is the only other person in my family with hypertension. I am the baby of 12 children and I only got it after my last baby.

I’m very familiar with the disease you know. I know that a stroke is brought on by stress. You know I’m a medical technician or you can call me a nurses assistant so I know a lot about hypertension. You better listen to me. It is nothing to play with. It will kill you. You have to listen to your body and to your doctor. Don’t play with it. If you are on medication take it religiously.

**Ms. Gretchen Green 04-P:** All of my children have high blood pressure, but won’t see about it.

I know that they call it [hypertension] the silent killer. It can kill you…… Cause kidney failure….. dizziness, cause I have those.

**Mr. Orin Orange 05-P:** I’m one of ten children. I had six sisters and three brothers. Now there are only five of us, two boys and three sisters living. I know my sister Ceil has it.

I know that you can get a heart attack and stroke from it [high blood pressure]. I know there are some things that cause it [high blood pressure] so I try to stay away from things like pork, salt, and collard greens.
A sub-theme that arose was that several patients were aware of the complications brought on from the disease, but weren’t willing to comply with the necessary precautions to make their quality of life better.

Ms. Baby Blue 02-P: All of my family suffers from high blood pressure. Strokes run in the family. My baby sister had to have one of her legs amputated. I’ve had it since 1981.

Hypertension alone has many variables…. like say your lifestyle. I’m much older now, if I knew what I was doing to my body many years ago I probably would not have done it. But I didn’t realize it so now I’m suffering from the chronic. I’ve been a smoker for forty years and I knew that was not a good thing, but I wouldn’t listen because I felt fine. I guess I thought I was invincible.

Mr. Yardley Yellow 03-P: My father has had I know, I know, two heart attacks. One was major. He has hypertension, but he just smokes, and smokes, and smokes. We can’t get him to quit.

I know that hypertension is the same as high blood pressure, and I know that you can have a heart attack, a stroke from it.

Caregivers’ Family Background and Familiarity. Several of the caregivers talked about how some of their relatives other than the patients they were caring for suffered with hypertension, some more severely than others. They also discussed how familiar they were with the disease:

Mr. Rudy Red 01-C: I don’t have any family members who suffer from it other than my wife.
I don’t know much about the disease, other than it is nothing to play with. I work at the hospital in the emergency room, but I really don’t know that much about it.

Ms. Sapphire Blue 02-C: My entire immediate family suffers with the disease; my parents and both sisters.

I am slightly, no somewhat familiar with the disease. I know that it could be genetic or it can be brought about by your lifestyle. Like what you eat, lack of exercise, stress. Things of that nature.

Mrs. Yolanda Yellow 03-C: There are only my husband and my son who has high blood pressure in my family. Maybe its because they are men, I don’t know. But I know that you can die from it, but my stubborn husband don’t think he can.

I know that high blood pressure can cause a heart attack caus my husband had two from it.

A sub-theme that came about was denial of having the disease, which is stage one of the Family Adjustment and Adaptation Response Model (FAAR Model).

Ms. Gwenneth Green 04-C: My mom has it and I have it, but I’m not claiming it.

Mom says her [daughter] pressure has been 200/100. (Interviewer ask “Are you taking medication?).

Ms. Gwenneth Green 04-C: No.
Interviewer ask why, since her [daughter’s] mother knows and says that it’s the silent killer.

Ms. Gwenneth Green 04-C: You go to the clinic…seems like you’re not getting the proper treatment. And if you don’t have insurance, you don’t have Medicaid, it’s just like, you know.

Ms. Gretchen Green 04-P: That’s no excuse.

Ms. Gwenneth Green 04-C: I know, that but if you don’t have insurance, the system is just so hard. You got to be dying or something in order to get on Medicaid or something, real real real poor. But if you have a job making a little money, you know, making a little money, you caught between a rock and a hard place. There is nothing for the middle people, the people who are working and trying to make a living, and can’t afford insurance, your just stuck,…….you really can’t afford insurance, and if you can, you can’t afford the doctor’s visit for $85 and if you sacrifice for that, then you can’t afford the medication. I know that it deals with a lot of things, your kidney, your heart.

Ms. Olga Orange 05-C: My mother and father suffered, and all my sisters and brothers suffer from high blood pressure. It is the most common reason of death in my family.

I know that it [high blood pressure] can cause a heart attack, stroke, and for some people impotence.

Need for Family Support

This theme emerged from the family support of each other in times of need expressed by participants. The fact that they did not agree on everything and encountered opposition on certain matters, did not prevent them from supplying emotional,
instrumental, and physical support when needed. Among the more serious complications and disabilities related to hypertension were those events that remove normal modes of existence. These included how the patient walks, what he/she eats, sexuality, mobility, reasoning ability, strength and even acceptance of self. For these reasons, in some cases the need for family support was high. In all cases, however, the knowledge and the reality of another individual within the family that the patient can communicate and/or interact with made coping much better and directed. The need for family support is also a consistent value between patient and caregiver.

**Patient Need for Family Support.** All of the patients interviewed and observed expressed a need for family support regarding coping with the disease. The patients’ responses were as follows:

**Ms. Ruby Red 01-P:** My husband is a big help, he does not put any pressure on me such as having sex. He fix my food and brings me juice. He helps me in and out of the tub. I can not get out of the tub. My left side won’t let me. In order to make your present circumstances better, you need a lot of understanding with your family and a lot of help and a lot of patience.

My husband is a good man, I don’t know what I would do without him. He is there for me. You know I told you that I don’t drive. If my husband was not there to take me places I don’t know…..it would be a strain. Children you know they are always so busy. They complain about helping, and my baby I think he’s ashamed sometimes. But they are good kids and they love me, they help out. My oldest son resented the fact that mom had a stroke. He was scheduled to go to Duke and he feels that I held him back….you know he was afraid to go for fear of me needing him. He was embarrassed as well. My slurred speech and limp in left leg. I know its hard on them, just like it’s hard on me.

**Ms. Baby Blue 02-P:** My sister, the one who lives here is a very gracious
person that I love a lot…(pause) very helpful, she’s been there for me for quite some many years. She’s my saving grace; she’s my angel. My mother has been deceased for five years now. I don’t know what I would have done without family, because they care about my health. That’s another thing, people that get elderly, you don’t realize it until you get older, but if family is not there, there’s not many people who care about you, who go the extra mile, and that’s very important for the elderly.

My other sister, she begs me to stop smoking.

Mr. Yardley Yellow 03-P: My mother is you can say my primary caregiver. She does a lot for me. She will take me shopping, to the movies, to do my laundry…..everything. As a matter of fact, I usually spend the weekends with them. My dad does not really do much for me, but I really don’t need him to. My sister in Tallahassee and my sister in Greensboro do what they can. No children really help me, my nieces and nephews are to small. I can really do everything for myself. I just can’t drive.

Man, I wouldn’t be alive had it not been for my cousins. You know, they made sure I went to the hospital when they called the paramedics.

Ms. Gretchen Green 04-P: My daughter is the only person who provides care for me (Phone rings).

*When interviewer asked about other five children helping, patient said she’d rather not answer*

Ms. Gretchen Green 04-P: But if I’m sick, people will come visit, but not provide care.
Mr. Orin Orange 05-P: My wife is the one who does most everything for me. My daughter and son and nephew care for me too.

Caregiver View for Family Support. The caregivers’ expressed how they felt in regard to assisting and supporting their loved ones in coping with the disease. Some caregivers showed general concern and interest in supporting the patient, but others seem to indicate that it put difficult stress on their own lives:

Mr. Rudy Red 01-C: My wife is on edge all the time. I just deal with it, realizing that she is not herself. She complains, she’s argumentative, I just don’t say anything. I deal with it by blocking it out.

When she comes home in an argumentative mood I know that what she is arguing about may not be the problem. I’ll listen, you know, and just pass it off, and in time you know, she calms down. I’m there for her. I know that it’s the disease affecting her. But she knows that I’m here for her.

I am concerned for her. I don’t like to leave her alone. I frankly don’t even like for her to cross that street out there cause I know she walks dragging that leg.

Ms. Sapphire Blue 02-C: In terms of my sister, I have been there for that girl. She use to live with me you know. But it was just too much. She would not clean up behind herself, she would constantly smoke and drink leaving debris behind. Once she was cooking and set the house on fire. It was just too much for me. Mind you, I too suffer with the disease, and it was too much stress. I feared having a stroke or a heart attack. I came to the conclusion that I could be more effective and more supportive if I helped her to stand on her own two feet. We found her a place and she knows I’m here
for her. I take her to her doctors appointments, to get her prescriptions filled, shopping, whatever she needs. She knows that I am here for her and that I love her.

Mrs. Yolanda Yellow 03-C: I help my son out more than anyone else in the family, but I’m suppose to I’m his mama. We do things, you know like shopping for grocery, going to the picture show, and riding, things like that. He likes that too. He can really do everything else like bath and feed himself. He aint know invalite. He might not be able to walk, but he can do every thing else. Now my husband, shoot, he can walk and I still have to brang him his food, run his bath water and everything else.

Ms. Gwenneth Green 04-C: I am the only person in the family who helps my mom. Her parents are dead, my dad is dead, and we won’t talk about my sisters and brothers. This has changed my lifestyle a lot. I have to spend a lot more time over there. And that takes time away from my immediate family. I have more time on the weekend so that’s better for me.

Ms. Olga Orange 05-C: I am pretty much the caregiver. Sometimes my daughter who lives here, and my son who does not will help some, but I would say I’m the only one pretty much. I help him take showers, he can’t really bend, it bothers him to sit down in the tub. Trying to learn him to take showers is very challenging. I haven’t been able to get him a bench, you know like they have in the hospital for the shower. My husband knows now who really cares and looks out for him. Don’t get me wrong, my daughter, grand kids, and son, all I have to do is pick up the phone.

The caregiver who also suffers from hypertension deals and copes with the
Ms. Sapphire Blue 02-C: My sisters are very supportive of me. I appreciate having them, doing things with them, just knowing that they are there. But I’m the type of person who does not necessary need positive reinforcement in terms of taking my medication. I know what is required in terms of me doing what is necessary to sustain my life. I guess you can say that I have an internal locus of control. Don’t get me wrong, family is a very, very, good thing to have; it gives you a sense of purpose, something to strive for in terms of prolonging life. I don’t have any children, none of my sibling, so it’s good to have their support.

Need for External Support

Associated with the need for family and more particularly, when there was no family to address the inherent need, patients turned to outside sources for comfort and care. This manifested as a need, which often linked the patient to other individuals outside of family or physician. In addition, patients with family support still needed some external support (e.g., agencies) to provide transportation, public health services such as Medicaid, therapy, and the like. External support was also provided by support groups, church, and social organizations and other individuals. Recognizably, these services and support were expressed as coping styles that are a part of the support system the patient needed to continue some level of interaction and quality in their lives. External support also assisted the caregiver in caring for the patient. These caregivers came to rely on these services heavily.

Patient Need for External Support. All of the participants interviewed and observed expressed a need for external support in terms of helping them cope with this disease. The patients’ responses are as follows:

Ms. Ruby Red 01-P: I go to speech therapy to teach me how to talk and physical therapy to teach me how to walk. What exactly do they do at speech and physical therapy for you? Probing question by interviewer. At speech
therapy they give me a card with words on them that we go over each and every word several times. They tell me how to pronounce and enunciate something like that. I have to use several muscles in my mouth and roll my tongue a certain way. In physical therapy they put this brace on my leg and a harness around me and they have me to walk at first holding on to the rail and then without holding on to the rail while they spot me.

Ms. Baby Blue 02-P: You know I used to live with my sister, but now I live at this senior citizen building. Where I live is wonderful, and they have HUD (Housing and Urban Development), and you should tell everyone about it. They really help us and they know a lot about all kinds of services.

_interviewer: Can you give me some examples?_ The Department of Elder Affairs helps me with SHINE (Serving Health Insurance Needs of Elders) 1-800-96ELDER) and I have Medicaid and Medicare and the HCFA (Health Care Financing Administration) helps me.

I go to the doctor for pain management to get a shot, but you can only get them three times a year. In order to walk, or whatever, I hate medication. I’ll take it for my high blood pressure, my thyroidism, and my heart, but I hate taking just pills. They clog up your body, they can mess with your liver; I really don’t even want to take those shots, but it’s only necessary for me to walk. I have to have them to cope with the situation.

Mr. Yardley Yellow 03-P: There are several outside agencies that help me. I don’t know if you have heard of SSI [Supplemental Security Income], but they help with my annual income.

Also Big Bend Transit takes me wherever I want to go. HMS which stands
for Habilitation Management Service takes me places and Gadsden GARC and I don’t know what that stands for but it’s a group of people who take me and get me things that I need. They are very nice and helpful.

Ms. Gretchen Green 04-P: 21st Nursing Assistant Organization is good to me. I have a aid who comes everyday and checks my blood pressure and weight. She also makes my bed, whatever I need done. Then they [21st Nursing Assistant Organization] sends a nurse out once a week. The people from the housing authority provides me with housing, and I get Medicaid, Medicare something.

Caregiver Need for External Support. It appeared that the majority of the caregivers were not even aware of outside agencies that provide assistance. If their loved ones were provided care, they were not aware of from whom:

Mr. Rudy Red 01-C: I really don’t know of any outside agencies or other individuals that help.

Interviewer: What about her children or other family members or friends?

Mr. Rudy Red 01-C: Not to my knowledge, naw.

Ms. Sapphire Blue 02-C: Well, I am not aware of any outside agencies that assist my sister. However, there are individuals in her building who may offer to get the door for her if her hands are full, or something of that nature.

Mrs. Yolanda Yellow 03-C: I think he uses a lot of services, but I can’t tell you who they are. If you ask him he can tell you.
Ms. Gwenneth Green 04-C: She [mom] has someone who comes by and helps some, they check her pressure and things like that, but maybe if they had some agencies to come by pick ‘em up take ‘em you know take ‘em places have somethings to do with ‘em somewhere, you know like to take them places do some things with them. Cause you know most times she’s afraid to leave because of her dizziness, she gets off balance you know. She does not want to go anywhere by herself.

Ms. Olga Orange 05-C: We can’t get any help from anybody. They always say we get too much income, and I don’t know where they get that from, because we have mortgage, utilities, bills, and bills, you know.

Coping Strategies and Techniques

Life situations necessitate degrees of adjustment or acceptance. Human beings are known to change circumstances to fit their needs. Sometimes the initiation of change is constrained by self-esteem, health, educational levels, social and economic factors, support systems or just the will to make things different. All of these enter in to the general terminology of “coping.” Furthermore, the ways by which coping is brought into effect (e.g., strategy and technique) may differ under different conditions or under the same conditions, but with different individuals undergoing the stress. Hence, many different coping strategies and techniques were identified within the sample. Isolation of any one of them or a group of them demonstrated the promotion of a common end point relative to disease state or a condition related to a disease state. Utilizing different techniques and strategies allowed patients to accommodate and adapt to the circumstance of their disease.

Patient Coping Strategies and Techniques. All of the patients discussed what they do in order to deal with the challenges brought on from Chronic Hypertensive
Cardiovascular Disease. Coping strategies and techniques includes dietary changes, exercise, medication compliance, keeping appointments, listening to the doctor, not complaining, not being stressed, social support, and giving up alcohol:

Ruby Red – 01-P: No matter what I eat, I never use salt. I don’t even cook with it. I listen to my doctor and take my medicine as prescribed. I don’t alter, because I don’t want to have another stroke. I also do a lot of walking.

Baby Blue – 02-P: I know you are not going to believe me, but I try to cope with this disease by taking my medication, having my sister to take me to my appointments. It’s hard sometimes, you know? But that’s how I cope.

Mr. Yardley Yellow 03-P: I try to cope with this disease by taking my medication regularly. I use to let things get to me so bad that I blacked out, they say for at least an hour. My cousins called the paramedics, but I didn’t remember blacking out. I went to the emergency room, they couldn’t fine anything wrong, finally, the only thing they could find is high blood pressure. Like I said, I stopped letting things stress me out, I had to learn to let it go.

Ms. Gretchen Green 04-P: I have a lot to try and cope with. My kidneys (end stage renal disease). I have problems urinating sometimes, but I don’t wear depends. No salt is hard, very hard. It’s hard for me to not keep my house clean. Cause I like my stuff neat. But the least little thing will run my pressure up. I don’t have to be stressed. Doing housework can cause it. There is no problem that is the easiest, all are hard. But I watch what I eat and take my medication. I guess being better could make my circumstances better, and more support, but I don’t complain.

Mr. Orin Orange 05-P: My eating habits. I definitely had to get off that salt.
It was hard, real hard. Sometimes my shirt would be wet from sweating.

Drinking alcohol was the easiest to give up. It was not hard at all. I also walk and ride my bicycle that sits on my porch two miles a day.

Caregiver Coping Strategies and Techniques. All of the caregivers discussed what they do in order to deal with the challenges brought on from Chronic Hypertensive Cardiovascular Disease. Coping strategies and techniques included providing comfort, social support, dietary changes, medication compliance, providing transportation for appointments, providing moral and emotional support, providing prayer, church, fishing, and education (reading about the disease).

Rudy Red – 01-C: I try to make sure that she is okay. If she is okay, I know that I can rest comfortably. I deal with the situation by trying to make sure that she is as comfortable as can be. I am basically the cook, so I don’t use salt. I remind her and check with her to make sure that she takes her medicine. I think she does okay for the most part.

Sapphire Blue – 02-C: I don’t think that I have to have a coping mechanism. We’ll I guess you can say that I feel that when I take my medication, I’m okay, and of course I go to the doctor every six months, and this last time I went, he did increase the dosage or gave me an additional medication, because I tend to have been done with it. I don’t have any problems with it at all. I’ve never gotten dizzy.

You asked me about coping didn’t you. Well I think watching what I eat, watching my weight and continuing to exercise. I don’t do as much exercise as I could, but I walk every day. One of these days as I keep saying, I’m going to really get heavy into the exercise. Maybe I might exercise a couple of times a week if I go to the Y [YWCA]. Umm, I was doing Tai Chi every Tuesday and Thursday and I would stay at the Y and work out some. I was
giving a class during that time so I became very lax with exercising although I’m doing a yoga class now. And I plan to exercise full-time when this semester is over, I feel that exercise will help a lot!

You can say that I am basically satisfied with my life in regards to the disease. I just actually don’t feel anything from it, and I take my medication every day. Every now and then I might forget, and if I go a day or so and I know I should not, I don’t have guilt feelings. I am coping with the situation very well I think, and it has not really changed my lifestyle. But you are concerned about my sister as the patient aren’t you? I am the one who questions her about taking her medication, and of course if she has to go to the doctor. I am the one who gets her there, stay and wait for her, and take her back home. I am the one who is providing morale, emotional, support and helping her to cope. I have problems with her because she continues to smoke, and does things that are detrimental to her; and we talk about that, but I haven’t been able to stop it. So, I pray for her and that helps me to cope with her situation that is out of my control. I have to rely on a higher being.

Mrs. Yolanda Yellow 03-C: I would say that the most challenging thing that is difficult is its hard looking at my son, knowing that he will never be able to walk. And just knowing that no one will probably ever marry him, and he will probably never give me any grandbabies. But I pray for him, that’s how I keep my head above water, and I thank God for giving him a good heart and a strong mind, caus he does not let it get him down this disease. I think that’s what helps me to cope. I would have to say that my baby is doing well considering the circumstances.
Ms. Gwenneth Green 04-C: I guess at this stage she [mom] done had it for so long, (mom says a life time), she’s not coping to good. I guess that comes from having it for so long. You just get tired, you’re not getting any better, you’re just getting worst, you’re just tired now, so you’re tired of goin to the docter, tired of this, because you know it seems like your pressure is not getting lower, it’s still the same. It’s not really getting any better.

Interviewer: Did they change the medication?.

Ms. Gwenneth Green 04-C: Yes, but it’s not getting any better. She [mom] has burns on her arms now from the patches (hypertension patches) and they didn’t work. Then they tried her [mom] on this other medication and it didn’t work cause it made her hallucinate, you know so…….

Mother interjects:
Ms. Gretchen Green 04-P: They want me to go to dialysis but I’m not going, cause I don’t think it will help. I have a sister on it. And I know how it done her.

Interviewer: How has it done her?
Ms. Gretchen Green 04-P: Mom says it is killing her. Her hair is gone, it makes her so sick, sicker than she was before she went.

Ms. Olga Orange 05-C: Cooking without salt. Mostly all the problems are easy for me, cause I have God and my mother’s wit. Some of the coping strategies I use as the primary caregiver are going to church, fishing, reading about the disease, I like to read and that helps me understand things. It is soothing, relaxing, and helps when looking out for other family members. I don’t let things get me down. The Lord does not want us to have no pity party.
I think that he [husband] copes really well. He knows that I’m here. I make sure he gets his medication, breakfast, lunch, and when I’m not here, I prepare it, and my daughter will warm it up and make sure he gets it. I take him to his appointments.

Taking medication is very important. I make sure I take mine and he takes his. But some men they won’t take it, cause they think it will you know, decrease their sex life, but it is important to take that medicine, very important. I tell my son, you know. Cause I asked him if he was taking his medicine, and he said yeah, every other day. He’s 51 and I told him, you’ve got to take it, but they think it’s going to affect their sex life.

Interviewer: Do you think they need a support system?

She[Olga] says that’s true, somebody to stay on them all the time, but he doesn’t have anybody to stay on him, so I talk to him all the time about his medicine.

Interviewer: So maybe you are his support system. What do you think?

Yes, I guess I am.

Socioeconomic Status (SES)

There has been an array of evidence that indicates that socioeconomic states (SES) is a strong predictor of health, regardless of access to medical care. It is not surprising to advocates for low-income people that research shows the poor have worse health than those with greater income. Higher levels of socioeconomic status (SES) have a direct correlation with lower levels of disease (morbidity) and death (mortality). This correlation has been identified using various measures of SES, including occupation, education, and household income (Kaplan, G., Pamuk, E., & Lynch, J., 1996).
Adler and Ostrove (2000) reported that the percentage of people with fair or poor health status continues to decline as income increases. For families with less than $15,000 in annual household income, 20.6% had fair or poor health. For those with $25,000-34,999 of income, only 8.1% had fair or poor health. Even comparing the two highest groups, households with $35,000-49,999 and households with $50,000 or more, we see a decrease from 5.9% to 3.7%. In other words, the more income increases, the more health improves. In addition, it is proposed that better health is linked with having more years of education, a more prestigious job, as well as living in neighborhoods where a higher percentage of residents have higher incomes and more education.

**Patient Socioeconomic Status (SES).** One of the patients did indeed talk about his socioeconomic status. His response is illustrated below:

**Mr. Orin Orange 05-P:** I also feel if something could be done for senior citizens to help with the cost of medication. When in the world are they going to do something to help us senior citizens with this medicine. I’m retired. I’m on a fixed income. Paying for that medicine is high and steady going up……although I try to take it, they say [doctor] I’ve got to have it, and I believe that. That’s why I take it, but it’s so expensive.

**Caregiver Socioeconomic Status (SES).** Several of the caregivers also were concerned that their financial limitations and challenges affected their ability to cope well with the disease. Their responses are illustrated below:

**Ms. Gwenneth Green 04-C:** You go to the clinic…seems like you’re not getting the proper treatment. And if you don’t have insurance, you don’t have Medicaid, it’s just like, you know. If you don’t have insurance, the system is just so hard. You got to be dying or something in order to get on Medicaid or something, real real real poor. But if you have a job making a little money, you know….making a little money, you caught between a rock and a hard place. There is nothing for the middle people, the people who are working and trying to make a living, and can’t afford insurance, your just stuck,…you really can’t afford insurance, and if you can, you can’t afford the doctor’s visit for $85 and if you sacrifice for that, then you can’t afford
the medication.

Mrs. Olga Orange 05-C: If we could get something to help with medicine. I’m on medication also. One medication is expensive, no all of his medication is expensive, mine too. I wish they would stop saying we get to much income. I wish we could get Medicaid. We are in the middle. He has a truck, we have to pay on the truck, I have a car, but I can’t pay the bill now that I don’t do part-time with Elder Care since August, so I guess they will be picking it up.

You know, we have a grown son, but he has his own children and own life, so we don’t ask him for anything you know.

Spirituality

African Americans throughout history have always held religion high on their totem poles. During slavery, religion appealed as a means of comfort, escapism, and maintaining a resistance to their White oppressors. Through times of depression, they felt that if they truly believed with all their heart, mind, and soul, that a divine intervention from this supernatural force would intervene and deliver them; give them strength to endure whatever obstacles they may encounter; guide them; and just be there for all of their needs, wants, and wishes. Thus, it is not surprising that these African Americans believed that there is a supernatural force that has great control over what happens in their lives.

Patient Spirituality. Although none of the patients verbally expressed any religious connotations, their beliefs were symbolized in the pictures, paraphernalia, and artifacts in their homes (e.g., pictures of Jesus and The Last Supper, huge ceramic angels, a black ceramic Jesus, Bible, praying ceramic hands, etc).

Caregiver Spirituality. Four of the caregivers expressed or displayed a need for spirituality in coping with the disease:

Ms. Sapphire Blue 02-C: I have problems with her because she continues to
smoke, and does things that are detrimental to her; and we talk about that, but I haven’t been able to stop it. So, I pray for her and that helps me to cope with her situation that is out of my control.

Mrs. Yolanda Yellow 03-C: I thought my husband was going to die after that second heart attack. Baby, I was sooooo afraid. I just kept praying and praying, and you know, God answers prayers.

It’s hard looking at my son, knowing that he will never be able to walk. And just knowing that no one will probably every marry him, and he will probably never give me any grandbabies. But I pray for him, that’s how I keep my head above water, and I thank God for giving him a good heart and a strong mind, caus he does not let it get him down this disease.

A coffee table holds a 2 ½ foot bible in Yolanda’s home. A picture of Jesus hangs on one wall. On another wall hangs a 3 ft. x 5 ft. picture of the Last Supper. In Ms. Gwenneth Green’s home, a few religious pictures hung on the walls. In one corner of the dining room, a curio displayed religious figures (e.g. a praying hand, and a Black Jesus on a cross).

Mrs. Olga Orange 05-C: The disease has not affected my lifestyle that much. That’s the amazing grace of God. I keep going because he knows people need me. I have to do more for my husband, and God provides me the strength to do it. He [God] knows people need me.

Mostly all the problems are easy for me, cause I have God. Some of the coping strategies I use as the primary caregiver are going to church. I don’t let things get me down. The Lord does not want us to have no pity party.
Patterns and Over-Arching Themes

Through further analysis, the patterns and over-arching themes that prevailed through the patients and caregivers interviews and observations were compared and contrasted. The similarities and differences are expressed below.

Similarities Between Patients and Caregivers

Patients and caregivers differed the least in fear and anxiety about the disease. They both experienced major changes in their lives, brought on by chronic hypertensive cardiovascular disease. They both knew that diets would have to be altered in order to prevent complications (e.g., stroke, heart attack, arteriosclerosis, coronary artery disease); that sexual activity may have to be altered or ceased to prevent a stroke or heart attack, and that medication would have to be in compliance. Patients feared losing the daily regimens in which they were accustomed, and caregivers feared if patient lifestyles weren’t changed, their loved ones health may become damaged and create severe lifelong problems. Both patients and caregivers agreed that the patient should listen to the doctor, take medication, and keep appointments with the physician.

Regarding family background and familiarity, the patients and caregivers all had one or more other family members who were known sufferers of the disease. They both knew of at least two complications (e.g., stroke, heart attack) that could arise from chronic hypertensive cardiovascular disease.

Both the patients and the caregivers expressed a great need for family support. Even though they may have had different views on certain issues such as when and if they should exercise, when and if they should eat certain things, they valued the support of family emotionally (i.e., person feels loved, cared for, and a member of a mutual network), cognitively (e.g., source of information), instrumentally (e.g., transportation), and physically (e.g., physical assistance).

The patients and caregivers both had the same outlook on coping strategies and techniques. They both felt that diet, exercise, medication compliance, appointment keeping behavior, being there in a time of need to assist with housekeeping (e.g., cleaning, cooking, etc.), aiding in bathing, clothing and any other form of assistance in
improving the quality of life of the patient were important factors in dealing with chronic hypertensive cardiovascular disease. The patients and all but one caregiver were in the low economic status bracket (See Figures 4a and 4b). Some patients as well as caregivers expressed a need for assistance with high medication cost and insurance premiums.

The patients and caregivers exhibited a strong spiritual believe in two different ways. Some articulated their belief verbally while others expressed theirs through symbols in their homes. But all believed in a powerful God who could help them.

Differences Between Patients and Caregivers

The one area in which patients and caregivers differed the most was the need for external support. The difference between the patient and caregiver was not based on views of the importance of such support, but the degree of knowledge of what was available and used by the patient. Although some patients were receiving care through agencies such as HUD (Housing and Urban Development), SHINE (Serving Health Insurance Needs of Elders), HCFA (Health Care Financing Administration), their caregivers were not aware. In one instance, the patient was receiving extended support such as speech and physical therapy. The spouse was not aware of any external support.

Overview

In reviewing the findings, the theme that prevailed or would be viewed as the strongest and “central core theme” would be “fear and anxiety of the disease.” This theme showed patterns of linkage to all of the other themes. Because of fear and anxiety of chronic hypertensive cardiovascular disease, the patients and caregivers exemplified the trust and dependency that they have in the physician. They tried to listen to the doctor even if they didn’t trust him/her one hundred percent. Paradoxically, fear and anxiety may have had a positive outcome in that they became more conscientious and familiar with the disease.

Because of fear and anxiety, the patient relied heavily on family and external support in terms of coping strategies and techniques used to help them through the needed changes in lifestyle. In addition, they can draw on their spirituality as another
form of coping strategy. Clearly, the patient and caregiver did not depend on one coping mechanism. But because of fear and anxiety of chronic hypertensive cardiovascular disease, a need to implement a variety of coping strategies became essential.

Perhaps the most significant conclusion is that chronic hypertensive cardiovascular disease does indeed affect lives in powerful ways. Physical disability, emotional fear and anxiety, and increased dependency on others change the lives of patients and caregivers in both daily and dramatic ways.
Figure 4a: Patient’s Income
Figure 4b: Caregiver’s Income
CHAPTER 5

DISCUSSION and IMPLICATIONS

Introduction

This study of a sample of North Florida African Americans living with chronic hypertensive cardiovascular disease has produced a more in-depth understanding of the families’ beliefs and experiences in relationship to coping strategies and techniques. The purpose of this study was to qualitatively determine perceptions, meanings, effects, and experiences related to chronic hypertension among African American patients and members of their families who serve as primary caregivers. More explicitly, the study was concerned with African American individuals as well as family members’ coping strategies and techniques in relationship to chronic hypertensive cardiovascular disease and the problems associated with the disease.

The general expectation is that interpersonal relationships, family life, and coping skills are related to disease processes, most times resulting in changes that affect the entire family throughout the course of the disease. This prompted the interest in this area of study. Furthermore, differences in disease consciousness, as well as coping strategies and techniques may sway medication compliance, patient progress, and healthy living.

These issues are addressed in this chapter and structured in the following sections. The first section presents a brief summary of the study. The second section presents a discussion of the findings. The third section presents a relationship of findings and research. The final section is devoted to a discussion of theoretical implications of the findings, limitations of the research, and future research directions.
Summary of the Study Design

This study was designed to phenomenologically investigate the coping strategies and techniques among a sample of African American patients in North Florida (using the social support theory and the health belief model), who are living with chronic hypertensive cardiovascular disease, and their family members who serve as their primary caregivers by understanding their world through their perceptions, meanings, and intentions. This was done by using ideals or examples from individual interpretations of the person’s lived world.

The method used was a purposive convenience sample of African American patients living in North Florida with chronic hypertensive cardiovascular disease for at least one year; and African American primary caregivers of these patients for at least one year. The total sample consisted of ten participants between the ages of 40 and 85 as shown in Figure 3. Two patients were male with the primary caregiver being female, and three patients were female with two of their primary caregivers being females and the other male.

Discussion of the Findings

The purpose of this study was to understand how African Americans and their families cope with chronic hypertensive cardiovascular disease. Data collected through observations, questionnaires, and interviews presented the following over-arching themes: 1) fear and anxiety of the disease; 2) dependency on the physician; 3) family background and familiarity; 4) need for family support; 5) need for external support; 6) coping strategies and techniques; 7) socioeconomic status; and 8) spirituality.

Both patients and caregivers agreed that their lifestyles would have to be altered to prevent complications of the disease such as stroke, heart attack, arteriosclerosis, peripheral vascular disease, and coronary artery disease. They both feared that if lifestyles weren’t changed, health of their loved ones could become detrimental and create harsh lifelong problems. The patients and the caregivers felt that the patient should keep their appointments with their physicians, listen to their physician, and take

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their medication.

Both patients and caregivers were knowledgeable, some more than others, about complications that could arise from the disease; and each had one or more family members who suffered from the disease. A great need for family and external support was exhibited. Diet, exercise, medication compliance, appointment keeping behavior, family support, and external support served as coping strategies and techniques for the patient.

The majority of the participants had low socioeconomic status as shown in Figures 4a and 4b. Thus, it is not surprising that medication cost and insurance premiums were of high concern for the participants, and that families valued a strong religious direction. This is consistent with Hill (1973) who argues that historically, one of the strengths or coping strategies with life trials and tribulations among African Americans is religious orientation.

It appears that the central core theme or pattern is “fear and anxiety related to the disease”. Fear and anxiety showed patterns of linkage to all of the other prevalent themes. Due to fear and anxiety about the disease, the patients and caregivers demonstrated the dependency and belief that they have in the physician. Ironically, a fearful state of mind can have the positive effect of the patient becoming more aware and familiar with the disease. In addition, because of fear and anxiety, patients seem to depend a great deal on family and external support (e.g., agencies, spirituality) in terms of coping strategies and techniques.

A related pattern identified in this study is that in coping with chronic hypertensive cardiovascular disease, even an individual who has rather close ties with his/her immediate family, must interact with individuals outside the family structure. External support may come through health care practitioners and agencies, or it may just come through individuals who have a humanistic concern for the individual or the situation.

Through the analysis of this data, one can infer that chronic hypertensive cardiovascular disease does affect lives in potent ways, and that coping acts as an intervening or mediating factor between stress and chronic hypertensive cardiovascular disease. Coping behaviors can also reduce the negative effects of life strains brought on
by this disease. This study seems to reinforce support for Lazarus’ (1976) theoretical framework which suggest that a person’s coping performance is structured not by emotions, but by the cognitive process that leads to the emotional response. However, we must keep in mind that coping varies significantly across situations for different individuals (Folkman & Lazarus, 1987).

**Relationship of Findings to Theory and Research**

The conceptual frameworks for this study were phenomenological theory, social support theory, and health belief model. Fear and anxiety about the disease reflected patterns of phenomenological theory where patients openly shared situations that they had encountered while suffering from chronic hypertensive cardiovascular disease. Consistent with van Manen’s (1990) perspective, the patients and caregivers rendered their experiences through story-telling. For example, one patient expressed her fear of becoming too stressed and for fear of having a heart attack or a stroke. Another stated the following.

**Ruby Red 01-P:** My mind isn’t as sharp as it use to be. It has affected my ability to think. I don’t drive anymore, it doesn’t mean that I can’t drive, or don’t want to drive, I just don’t want to drive. That’s what’s set in my mind. The fear you know?

A theory as proposed by Harding (1981) states that many African Americans believe that because they have survived the encounter of slavery that they are almost invincible. This health belief termed “fatalism” is one of the reasons why there are African Americans who do not see hypertension as a threat (Vaughan, 1993). “Fatalism” is defined as the belief that since African Americans have been through so much in this country (i.e., slavery, poverty, pain and mental anguish from past experiences) that hypertension is not perceived as a threat. Some evidence of this theory was supported by one patient’s comment about her life of trials.
Baby Blue 02-P: I know that I should not smoke. You want to hear this? I’m gonna tell it like it is. I know I should stop, and I’m afraid of what’s going to happen if I don’t……..but you want to know……..you want to know. You know what it’s like to be raped? Well, I’ve been there. It hurts my body. I take a drink or a smoke to try to forget………….NOW THAT’S THE DAMN TRUTH AND I’M THROUGH WITH IT!

Due to the fact that some African Americans are faced with so much misfortune (e.g., poverty, violence, AIDS, unemployment), many in the community no longer have regard for their own lives. Many will make comments such as “Well, I’m going to die anyway, so what difference does it make?” (Vaughan, 1993). However, in this study, that was not the case. Patients valued life and the quality of it.

The first research question proposed in this study was what does chronic hypertensive cardiovascular disease mean to African American patients and primary caregivers in North Florida? This particular disease meant that the patients and primary caregivers altered their lifestyles to improve their health, reflecting the health belief model. Some expressed a restriction in diet. Some patients articulated that they had to give up certain vices such as smoking, chewing tobacco, and drinking, while others spoke of physical restrictions that they now encounter. They all were somewhat familiar with uncontrollable risk factors (e.g., age, genetics) and controllable risk factors (e.g., smoking, obesity, drinking, environmental stress).

The second research question dealt with experiences patients and primary caregivers perceive as most significant in relationship to chronic hypertensive cardiovascular disease. Based on the research conducted in this study, it was found that the patient’s and caregiver’s ability to possess problem solving skills were professed to be significant by most participants, reflecting the social support theory. Most of the patients and caregivers exhibited an internal locus of control and positive coping strategies for stressful events. Shoeneman, Rezniko, and Bacon (1983) advocated that this personality trait is tremendously useful in determining a personal sense of adjustment to chronic hypertensive cardiovascular disease.

Theoretically speaking, the majority of patients and primary caregivers in this
study learned specific illness-related procedures. They demonstrated another coping or problem solving skill known as information seeking (e.g., looking up medical information; watching television programs about illnesses; finding several solutions to the problem; asking for advice). They sought comfort from others, and they took refuge in activity and their spiritual beliefs. There was only one patient who exhibited an external locus of control. Baby Blue relied on others to determine her fate. She also favored a negative coping strategy known as “wish-fulfilling fantasy.” In addition, this particular individual exhibited patterns of denial, which exemplified stage one of MuCubbin, Sussman, and Patterson’s (1983) FAAR Model. Along with positive coping strategies, negative coping strategies such as selective ignoring and blaming past experiences were also present to some degree.

The third research question dealt with coping strategies and techniques patients and primary caregivers identified in dealing with chronic hypertensive cardiovascular disease, and social support was found to be a component in coping. Family support is a component of the social support theory that is believed to have a bearing on ones ability to comply, improving the patients well-being. At the same time that living with a chronic disease can be devastating to the patient and to family members, family support was found to play an important part in coping with the disease. Family support emphasizes keeping the family functioning as a unit, maintaining a high level of esteem and emotional support, making sure tension is low, and accepting the demands of daily life. Social support has been shown to improve a person’s ability to cope with the stresses of life (Cohen & Wills, 1985).

Social support from families was a very important factor in the patients’ ability to cope in the present study. Social support is no longer a question in improving care. Because of the support from family, these patients were able to manage better.

Ruby Red 01-P: My husband is a big help. He fix my food and brings me juice. He helps me in and out of the tub. I can not get out of the tub. My left side won’t let me. If my husband was not there to take me places I don’t know….it would be a strain.
Baby Blue 02-P: My sister, the one who lives here is a very gracious person that I love a lot…very helpful, she’s been there for me for quite some many years. She’s my saving grace; she’s my angel. I don’t know what I would have done without family, because they care about my health.

Patients with family social support tend to be more in compliance with health behaviors such as appointment keeping, weight control, and blood pressure control (Belgrave & Lewis, 1994). This study similarly found that the family’s social support play a positive role in the prevention and reduction of stress. It provided general emotional sustenance; modified negative stress; strengthened hope and morale; and enhanced abilities to learn and use new skills in new situations.

The fourth and final research question addressed external influences that patients and primary caregivers believe are important in coping linked to social support theory. The patients and primary caregivers relied a great deal on physicians, other health care providers that provided therapy, Medicaid, agencies that provided transportation and housing, and social groups and organizations such as the church. Spiritually was present in some shape or form in all of the families interviewed. If the patients or primary caregivers weren’t praising their God verbally, their homes displayed the faith they had in a superior being in terms of coping with trials and tribulations. According to Frazier and Lincoln (1974), spirituality has been found to be of great significance to African American culture because in the past it was viewed as a “refuge in the hostile White world.” (p. 44). It has been suggested that spiritual beliefs can help people cope with health concerns, partially because spiritual beliefs help people face issues of living (Marty & Vaux, 1982). This study clearly supports spiritual experience as social support and a key component of health belief.

Research has shown that it is likely that older African Americans draw on health beliefs, behaviors, and traditional medicine founded on long standing cultural patterns. These health beliefs and practices were handed down from parents and grandparents, and where possible, from slaves. These cultural patterns varied, depending on “class” and education (Watson, 1984). Traditional health beliefs and practices among American Blacks and their historical roots was the folk medical system as practiced and believed by
American Blacks to be a composite of African and early European folklore. It is a combination of voodoo religion, root work, hoodoo, and spiritualism of the West Indies, herbal medicine from Africa, fundamental Christianity, and magic (Hurston, 1990). 

The narratives from the families in this research regarding health behaviors were symbolic of the health belief model. These patients and primary caregivers believed that the service provided by the physician would be advantageous in decreasing their vulnerability or the harshness of the condition. They developed a dependency on the physician:

Ruby Red 01-P: Do what your doctor says. Take your medicine. I believe in him and he takes care of me.

Baby Blue 02-P: Make sure you get check ups. Listen to your doctor.

Yardley Yellow 03-P: I take my medicine that my doctor prescribed daily.

Gretchen Green 04-P: I believe what my doctor says most of the time, but not all the time. Like I take my medicine, but sometimes it seems that it is not doing any good, you know. But I still believe him and does what he says.

Sapphire Blue 02-C: Well, definitely get yearly or six-month examinations by a doctor. You definitely take the medication that’s prescribed.

Further analyses were made of coping with the disease from a spiritual point of view. The results of the current study and other empirical findings propose that levels of coping appear to directly influence family outcomes (McKenry & Price, 1994). In addition, spiritual beliefs serve as a guide for health choices and decisions. Some questions have been raised in the meaning of health belief and spiritual integration as reflected in African American culture (Roberson, 1985). Work of several researchers (Baer, 1981; Griffith, English, & Mayfield, 1980) suggests that African-Americans’ use of spiritual or religious resources in health concerns is a coping mechanism, especially
for the poverty stricken (Baer, 1984; Hill & Mathews, 1981). Baer states that the position of spiritual churches in the black community is complex. Spiritual religion concerns itself at the individual level with the real problems and needs of persons living in black urban ghettos. Within this religious system, a complex of spiritual prophets and advisors, known as mediums, constitute a variant of black ethnomedicine.

In contrast to the professional doctor, the spiritual medium is a “poor person’s doctor” (Baer, 1984, p. 173). The services more closely match the economic means and the worldview (i.e., African ancestry and their conversion to Christianity during slavery) of the patient. The spiritual medium provides a service for a donation or a few dollars, whereas the professional doctor may charge $95 or more. In addition, the service provided will usually be in the patient’s home, at the medium’s home, the church, or somewhere else in the neighborhood, thereby making help accessible. However, the patients in this study may have relied on God, but did not replace medical professionals with a “medium” or other non-educated healers.

In this study all of the patients and most of the primary caregivers with the exception of one were of low socioeconomic status (See Figures 4a and 4b). Socioeconomic context dictates the types of affordable treatment and whether this treatment will take place in the professional or folk sector (Helman, 1990). Anderson (1992) suggests that African American patients who live in poverty stricken environments are exposed to more psychosocial stressors, such as higher unemployment, higher poverty rates, lower status occupations, and residential crowding. Some research has examined the relationship between a number of these factors, perhaps reflecting hypertension in African Americans. For example, African Americans living in high stress neighborhoods (e.g., low socioeconomic, high crime) had higher blood pressure than African Americans living in lower stress neighborhoods.

In this study, the majority of the patients were at least half a century old. With advancing age also comes increased risk of chronic and life-threatening illnesses such as chronic hypertensive cardiovascular disease, that requires health care intervention by medical practitioners. The high incidence of poverty among these patients and the ethnic minority background (e.g., African American) and the low likelihood of them having private insurance to supplement public insurance (i.e., Medicaid) may sharply reduce
access to health care. Some of the patients and primary caregivers expressed concern for help with their medical needs. They discussed how most were on several medications, and how one prescription was so costly, that they could not afford to purchase the others. Some could not receive Medicaid and didn’t understand why. Those who had retired and were on fixed incomes felt like they should be eligible. They stated that when they did work, their income level was below $25,000 annually.

**Implications of the Study**

There are three main areas of implication relative to the findings of this study that can be addressed. One is the relationship of the themes to education of patients as well as support personnel. The second is the relationship to service (primary or secondary). Third, is the relationship of the study to other research necessary to provide answers to associated questions.

**Implications for Education**

There are several core issues that undergird patient education. A primary issue is the provision of sufficient knowledge to create an understanding and/or acceptance of a given situation. Throughout this dissertation study and among all subjects (i.e., patients and caregivers), knowledge of the disease created a level of anxiety coupled with fear. Interestingly, the role of the physician as well as other caregivers were sources of knowledge acquisition. Patients consistently expressed a need to know.

The implication of this is clear. In most cases, patients who are well educated about their disease demonstrated a greater willingness to follow through on suggestions of care. Furthermore, although family support and external support were influential in determining levels of coping and its associated strategies, patient education was an essential component. Individual patients (e.g., Ruby Red and Baby Blue) expressed different levels of coping and education about disease outcomes. Yet, they both had some fear and anxiety.

Educators must design programs and curricula to provide information inclusive of both patients and caregivers. Some curriculum topics for patients could be “Early
Implications for Service Agencies

The health care system is one of several social support systems serving the needs of populations. Among African American hypertensives the need for this social support has been discussed extensively. The parts of the system are interactive and interdependent relative to the care of the patient. Of critical importance is the delivery of satisfactory medical care to patients of all ages and classes and that any deficits in delivery of care are identified and corrected.

A clear implication of the present study is the need to establish other avenues of care such that the low confidence and fears expressed by the patients can be readily handled. Service agencies should provide means of disease recognition and understanding, with the goal for patients to become more astute in designing personalized strategies to overcome identified problems and improve coping outcomes.

A good example of a service related need was for help with medical expenses. Their concern was that the cost was too high and that it was steadily rising. They believed in their physicians and therefore wanted to comply with medication intake requirements. Yet, they stated how hard it was for them to purchase medications. One thing that service agencies can do to help patients with their medical expenses is to educate the community about the available assistance through public service announcements, on television and radio, literature distributed at central locations, and mail outs to patients. Some patients and caregivers are aware of some programs such as Medicaid and Medicare, but most people don’t know that there are other programs such as Patient Assistance. This program is designed for patients who do not qualify for Medicaid and Medicare, but are uninsured because their income puts them in a bracket that prevents them from qualifying for Medicaid and Medicare, yet does not allow
enough for the high cost of medication. These patients can get medication through the
drug company. However, it is very time consuming and most doctors don’t have the time
nor staff to complete the large amount of forms required. So most will provide some
samples. Nevertheless, this will not sustain the patient until his or her next visit and
community agencies should address this problem.

A complicating issue was that some of the patients lived in environments that
were not conducive for safe nor healthy living. One patient has a watch dog to help
prevent break-ins because she lives in an a drug infested neighborhood. Another
patient’s home is so warm, because she keeps all of the windows and doors (even
screened door) locked and shut down for fear that someone will rob her. She too lives in
a high crime, drug contaminated neighborhood.

These observations challenge researchers to look at community-based living as
alternative situations for older African Americans with this disease in order to provide
better patient outcome. However, within minority communities, such establishments are
rare. Within the community from which subjects were drawn, there were none.
However, one church in the community wrote and submitted a proposal to HUD
(Housing and Urban Development) and was awarded a grant to build approximately 60
one bedroom apartments. This small community-based living provides educational
programs on safety awareness and health-care, and certainly cold incorporate topics such
as chronic hypertensive cardiovascular disease.

**Implications for Future Research**

Some of the critical health needs of the American society are directly related to
cardiovascular disease of which hypertension remains a large component. Studies such
as this one help to elucidate problem areas as well as to point to solutions. Individuals
live under the hope that cures will soon be available for the world’s diseases.

Concern and fear of worsening health are prevalent among patients. Although
this was not true of all the patients of this study, it was certainly the most common theme.
New knowledge arising out of scientific investigations often proves to be a stimulus to
new research. The implication is that more research in a field will help to solve existing
as well as new problems. Thus, both the patient and the caregiver results of this study can contribute information to developing new studies.

Integrative research teams should simultaneously investigate medical, sociological, psychological and economical aspects of coping-related questions and problems. In addition, the following areas seem to be extremely relevant to future research:

1. Use of “Internal Locus of Control” or intrinsic motivation instruments to identify areas of autonomy and independence. The researcher would compare patients with internal locus of control and external locus of control for the autonomy and responsibility in managing their disease. They would be compared to see if there are differences in coping strategies between those with internal and external locus of control.

2. Use of quantitative methods to correlate anxiety and stress management in this population of family members and patients. The researcher would suggest quantitative comparisons between patients and caregivers regarding their feelings about each other’s coping strategies and satisfaction with each other’s role in the coping process.

3. Quantitative measures regarding patient and caregivers perceptions of the degree of reliance on each coping strategy identified in the present study and the perceptions of how valuable each strategy is (also comparing patients with caregivers on perceptions) should be implemented.

4. Implementation of a longitudinal study to examine the nature of social support over time. The researcher would conduct more in-depth qualitative interviewing over several months to gain more depth of insight from caregivers and patients and to see if patterns in coping emerge over-time or based on life situations that come up. In addition focus group interviewing of patients and caregivers regarding their fears and coping strategies and suggestions for what would help them would add further depth of insight.

5. a) Drawing on qualitative and quantitative methods to examine spirituality and its impact as a coping strategy.
b) For example one question from this research is: Do low income people differ from high income in the degree to which they depend on spirituality?

c) Quantitative surveys should be used to compare high income and low income patients for use and success in using spirituality and other coping strategies.

6. Compare male patients to female patients in terms of coping strategies and techniques.

7. Identify medications to outcome and coping intensity. Medical professionals and social scientists should collaborate to identify ways that medical solutions and social psychological factors are interrelated.

**Limitations of the Study**

The following are limitations that were found in conducting this research:

1. In reviewing the demographic questionnaire, the income ranges that were used did not allow accurate reflection of incomes for the subject. The ranges were $10,000-20,000, $20,001-30,000, $30,001-40,000, $40,001-50,000, $50,001-60,000, $60,001-70,000, $70,001-80,000.

2. The data collected in this study can only be generalized to African Americans living in a small region of North Florida.

3. The use of self-report questionnaires limited the study to the participant’s ability of introspection, their memory, and their personal interpretation of each question.

4. There was a paucity of literature that addressed coping skills of African American families living with chronic hypertensive cardiovascular disease.

5. The sample size was small. However, the sample did provide detailed and vivid stories to illustrate significant themes that could possibly be common in the larger population.
Contribution to Knowledge

In summary, the study makes several important contributions to understanding chronic hypertensive cardiovascular disease among African American patients and their families living in North Florida. First, a person’s health and behavior are affected by his or her health beliefs; second, social support was found to be significantly associated with positive health behaviors; and third, fear and anxiety of the disease was found to be the central core theme.

Firstly, if patients feel that medication prescribed will increase the quality and longevity of life, they will be more inclined to take it. If patients feel that exercise and diet would be beneficial in decreasing either their vulnerability to or the harshness of the condition, and if they believe that the probable costs of taking action are outweighed by benefits then they will comply. Education plays an important factor as well. Patients knowledgeable about his or her disease will help influence medication compliance, exercise regimen, and diet, which will increase patient progress toward healthy living.

There is a lack of a focus on education, specific to the disease in its various stages, in other research. This study underscores the role that knowledge plays in taking appropriate steps to control the disease. Educational programs need to be created that should be an ongoing part of medical treatment through clinic workshops, churches, and other community agencies that are used by patients. Other information and practical helps could be printed and diagramed with easy to read pamphlets that could be distributed in clinics and agencies. Because of patient dependence on caregivers, education must include those who assist patients. Caregivers in this study did not always know that patients used community service agencies, and this should be as much a part of their education as factual knowledge about the disease itself.

Secondly, social support strengthened the morale and hope of the patients and modified negative stress. The social support that was provided by the family helped the patients to cope with life’s stresses. The patients tended to adhere to medication prescribed by their physicians; they tended to exercise more frequently; they monitored their food intake and kept their doctors appointments. The social support that was provided externally helped with transportation, public health services (Medicaid,
therapy), and support groups. The church as well as spirituality provided support that was needed to continue some level of interaction and quality in their lives.

Other literature did not address the coping strategies and techniques that African Americans living with chronic hypertensive cardiovascular disease needed to maintain a quality style of living. However, this study shows the relationship between the patient and caregiver and how the patient did depend and rely on the caregiver for social support. This study also shows that social support is just as important as medical support.

Thirdly, fear and anxiety proved to be the center core of all the themes relative to chronic hypertensive cardiovascular disease. Because of fear and anxiety about the disease, the patients and caregivers showed the dependency and belief they have in the physician. Paradoxically, that fearful state of mind had a positive effect of making the patient more aware and familiar with the disease.

Because of fear and anxiety, the patient depended a great deal on family and external support in terms of coping strategies and techniques. It was also found that even though a patient may have close ties with family, they must interact with individuals outside the family structure (external support). This may be through agencies, health care providers, or just through some individual who has a kindred spirit and a concern for the circumstance.

Fear and anxiety need to be paid attention to by all social support agencies. Social support agencies need to look at the heart of the person with this disease. They should also help them in understanding that if they have to give up something maybe they can find a substitute. An example would be that if salt has been restricted from their diet then maybe they could use a product known as “salt substitute.” It is so hard to give up certain vices (e.g., salt, cigarettes, alcohol) without social support.

This research project has provided enlightening insights into the experience of living with chronic hypertensive cardiovascular disease among African Americans. It becomes an integral part of the patient’s daily life—emotionally, cognitively, and behaviorally. Although patients and their caregivers cope in various ways, this study shows that more education and research focusing on relieving fears, connecting patient needs with the best services, and assisting caregiver’s is needed.
APPENDIX A

CORRESPONDENCE WITH CARDIOLOGISTS
The Florida State University
College of Human Sciences
Department of Family & Child Sciences
Tallahassee, FL 32306
September 2, 2002

Dr. Bryce Chandler
222 Physicians Drive
Suite 200
Tallahassee, FL 32322

RE: Research Study: Expressed Coping Strategies Among African American Families in North Florida Who Are Living with Chronic Hypertensive Cardiovascular Disease

Dear Dr. Chandler:

My name is Lisa Lang, and I am a doctoral candidate at Florida State University, College of Human Sciences who is interested in conducting research involving patients who suffer with Chronic Hypertensive Cardiovascular Disease. This research is part of the requirements for my doctoral degree.

Pursuant to our telephone conversation, I am most appreciative of the fact that you have given your tentative approval for me to invite patients from your practice in support of this important research project. The study of patients with heart disease and their families is very important to me, especially since heart disease is the #1 killer of men and women in this country and many other countries as well. Primarily as a result of this, I have elected to investigate chronic hypertensive cardiovascular disease patients and their primary caretaker for my dissertation study.

I am excited about moving forward with my study at this time. I have also received approval to begin my study from my dissertation supervisory committee and the Human Subjects Review Board at Florida State University.

Please take a few minutes and complete the attached consent form and return it to me in the returned addressed envelope as soon as possible; or you may leave it with your receptionist and I will pick the form up from your office while visiting the week of September 9, 2002.

Sincerely,

Lisa Lang
Doctoral Candidate
To: Lisa Lang, Doctoral Candidate

Re: Research Study: Expressed Coping Strategies Among African American Families in North Florida Who Are Living With Chronic Hypertensive Cardiovascular Disease

__________ yes, I consent for patients from my practice to participate in the research study entitled: Expressed Coping Strategies Among African American Families in North Florida Who Are Living With Chronic Hypertensive Cardiovascular Disease by Lisa Lang.

__________ no, I do not consent for patients from my practice to participate in the research study entitled: Expressed Coping Strategies Among African American Families in North Florida Who Are Living With Chronic Hypertensive Cardiovascular Disease by Lisa Lang.

Name of the person who will make a list of patients.

__________________________________________

When can I obtain the list or start identifying patients?

__________________________________________

Results of Research Study:

__________ yes, I am interested in receiving results (group data) of the research at the conclusion of the study.

__________ no, I do not desire to receive results (group data) of the research at the conclusion of the study.

__________________________________  _____________________________
(physician’s signature)                (date)

Thank you again for your assistance in this study.

Lisa Lang, Doctoral Candidate
APPENDIX B

RESEARCH QUESTIONS
RESEARCH INTERVIEW QUESTIONS  
(For Patient)

This research study which is qualitative in nature, is conducted to gather data for the analysis and interpretation of the following research questions:

1. How familiar (what do you know) are you with Chronic Hypertensive Cardiovascular Disease?

2. Are there other individuals that provide care that have been meaningful to you?

3. How has the disease affected you and your lifestyle generally; in other words, how has your life changed (informal)?
   a. Family (give an example of a family situation affected; how did you address the situation?)
   b. Work (give an example of a work situation affected; how did you address the situation?)
   c. Personal lifestyle (give an example of a personal lifestyle situation affected; how did you address the situation?)

4. What problems are the most challenging/difficult brought about by this disease? What problems are the easiest to cope with brought about by this disease?

5. Are there outside agencies that help?

6. Are there children that help?

7. In your opinion what could be done to make the present circumstances better?

8. Do you feel you have enough support?
This research study which is qualitative in nature, is conducted to gather data for the analysis and interpretation of the following research questions:

1. How familiar (what do you know) are you with Chronic Hypertensive Cardiovascular Disease?

2. Are there other individuals who provide care that has been meaningful other than you?

3. How has the disease affected you and your lifestyle generally; in other words, how has your life changed (informal)?
   a. Family (give an example of a family situation affected; how did you address the situation?)
   b. Work (give an example of a work situation affected; how did you address the situation?)
   c. Personal lifestyle (give an example of a personal lifestyle situation affected; how did you address the situation?)
   d. Is the weekend a better period of time to provide care?

4. What problems are the most challenging/difficult for you as the primary caregiver, brought about by this disease? What problems are the easiest to cope with as the primary caregiver, brought about by this disease?

5. Are there outside agencies that help?

6. Are there children who help?

7. In your opinion what could be done to make the present circumstances better?

8. What is your assessment of the patient coping with the disease?
APPENDIX C

THE DEMOGRAPHIC QUESTIONNAIRE
Demographic Questionnaire

Please answer the following questions by placing an X in the space that reflect your answer:

What is your gender?

_____ Male  _____ Female

What is your age?

_____ 20 – 29
_____ 30 – 39
_____ 40 – 49
_____ 50 – 59
_____ 60 – 69
_____ 70 – 79
_____ 80 – 89

What is your present marital status?

_____ Never Married
_____ Married
_____ Widowed
_____ Divorced

What is the highest level of education you have obtained?

_____ 6th grade and below
_____ 6th grade to 9th grade
_____ 9th grade to 12th grade
_____ A. A. degree
_____ B. S. degree
_____ M. S. degree
_____ Ph.D. degree

Employment:

a. If employed (Please check ONE)
   _____ Full-time   Occupation____________________
   _____ Part-time   Occupation____________________

b. If NOT employed (Please check ONE)
   _____ Retired   Occupation____________________ (Previous)
   _____ Unemployed (not disabled)   Occupation____________________ (Previous)
   _____ Unemployed (due to disability)   Occupation____________________ (Previous)

What is your household's annual income?

_____ $10,000 or less
_____ $10,001 – $20,000
_____ $20,001 - $30,000
_____ $30,001 - $40,000
_____ $40,001 - $50,000
_____ $50,001

Relationship to patient

_____ Patient   _____ Child
_____ Spouse   _____ Other
_____ Sister   _____ Brother
Do you live alone? ___________________ (If no, with whom do you live?)

____________________________________________________

Do you have a support system outside the family? ____________ (If so, with whom?)

____________________________________________________

What type of coping strategies and techniques are practiced by the patient?

____________________________________________________
APPENDIX D

OBSERVATION GUIDE
OBSERVATION GUIDE

Setting (environment, lighting, atmosphere):

Attitudes of individuals in the home:

Interaction between family members:

Communication between family members (verbal and non-verbal):
APPENDIX E

INSTITUTION REVIEW BOARD
HUMAN SUBJECTS APPROVAL LETTER
APPROVAL MEMORANDUM (for change in research protocol) from the Human Subjects Committee

Date: October 15, 2002
From: David Quadagno, Chair
To: Mrs. Lisa Lang
     P. O. Box 6098
     Tallahassee, FL 32314
Dept: Family and Child Sciences
Re: Use of Human subjects in Research
     Project entitled: Expressed Coping Strategies Among African American Families In North Florida Who Are Living With Chronic Hypertensive Cardiovascular Disease

The memorandum that you submitted to this office in regard to the requested change in your research protocol for the above-referenced project have been reviewed and approved. Thank you for informing the Committee of this change.

A reminder that if the project has not been completed by March 19, 2003, you must request renewed approval for continuation of the project.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: Dr. Marsha Rehm
chgapp.doc
APPLICATION NO. 02.144
APPENDIX F

INITIAL CONSENT FORM
Hello, my name is Lisa Lang. I am a Family Relations doctoral candidate at Florida State University. I am interested in the impact that hypertensive cardiovascular disease (i.e., hypertension/ high blood pressure) has on the African American family. Dr. Bryce Chandler has given me permission to invite his patients to participate in my study with your consent. Would you be willing to participate in an interview and answer a few questions about how this disease has affected your life? (e.g. how do you cope with the problems brought about by the disease, do you have enough support, are there outside agencies and/or other individuals that help).

If yes, please sign the form giving me permission to contact you.

_______________________________  _________________________
Signature      Phone Number
APPENDIX G

TELEPHONE FOLLOW UP
Hello, my name is Lisa Lang. I am a Family Relations doctoral candidate at Florida State University. I am delighted that you have agreed to participate in the study addressing “Expressed Coping Strategies Among African American Families in North Florida who are Living with Chronic Hypertensive Cardiovascular Disease.”

My focus is on certain events within family life that may have been altered due to the disease. What I would like to do is interview you and have you complete a small demographic questionnaire. I would like to do this in the comfort of your own home and at a time that is convenient for you. I would also like to know if the person who serves as your primary caregiver is available? I would like to interview him/her and have him/her complete a small demographic questionnaire as well.
APPENDIX H

INFORMED CONSENT FORM
INFORMED CONSENT FORM

I freely and voluntarily and without element of force or coercion, consent to be a participant in the research project entitled “Expressed Coping Strategies and Techniques Among African American Families In North Florida Living With Chronic Hypertensive Cardiovascular Disease.”

The research is being conducted by Lisa Lang, who is a Ph.D. candidate of Family Relations in the College of Human Sciences at Florida State University. I understand the purpose of her research project is to better understand the coping patterns of families with members who suffer with chronic hypertensive cardiovascular disease. I understand that if I participate in the project I will be asked questions about coping patterns that are exhibited by me as well as a selected member of my family.

I understand I will be asked to fill out a paper and pencil questionnaire. I will also be asked to participate in an interview that will be taped with the researcher. These tapes will be kept by the researcher in a locked filing cabinet. I understand that only the researcher will have access to these tapes and that they will be destroyed by April 2003. The total time commitment will be between one to two hours. My questions will be answered by Mrs. Lang or she will refer me to a knowledgeable source.

I understand my participation is totally voluntary and I may stop participation at anytime. All my answers to the questions will be kept confidential to the extent allowed by law and identified by a subject code number or fictitious name. My name will not appear on any of the results.

I understand there are benefits for participating in this research project. First, my own awareness about my health may be increased. Also, I will be providing valuable knowledge about family patterns of behavior in relationship to coping with chronic hypertensive cardiovascular disease. This knowledge can assist professionals in providing services that help families manage chronic hypertensive cardiovascular disease.

I understand that I may contact Mrs. Lisa Lang at 850.656.6864, 850.545.9811 or lgl7836@garnet.acns.fsu.edu, or Dr. Marsha Rehm at 850.644.7776 for answers to questions about the project. Results of the study will be sent to me upon my request. If you have additional questions you may contact the Institution Review Board (IRB) located at 100 Sliger Building, Tallahassee, FL or at 850.644.8633.

I understand that this consent may be withdrawn at any time. I have been given the right to ask and have answered any questions concerning the study. Questions, if any, have been answered to my satisfaction. I have read and understand this consent form.

_________________________________________  _______________________________________
(Participant)     (Date)
APPENDIX I

MAP OF NORTH FLORIDA
MAP OF NORTH FLORIDA
REFERENCES


BIOGRAPHICAL SKETCH

Lisa Gaytrina Jones Lang was born in West Palm Beach, Florida. After graduation from Twin Lakes High School where she reigned as “Miss Twin Lakes High,” she attended Florida A&M University as an education major. From Florida A&M University she received a Bachelor of Science degree in Business Education in 1981, a Master of Applied Social Science degree with a specialization in Public Administration in 1988, and a Master of Science degree in Business Education in 1997.

In the Fall of 1999, she was accepted into Florida State University’s College of Human Sciences to pursue the Doctor of Philosophy degree in Family Relations, in the Department of Family and Child Sciences, where she completed her Doctor of Philosophy degree in the Spring of 2003.

She is a very generous woman whose interests and activities include working with people who are in need, and who are less fortunate. She works as a volunteer for Big Bend Hospice and the Outreach Ministry at Bethel Baptist Church. Her humanitarian work has not gone unnoticed. In 1999, she received the Volunteer of the Year Award. She has provided leadership for a number of organizations through her work on various committees. These include the National Association of Colleges/Universities Business Officers, National Consortium for Graduate Degrees for Minorities In Engineering and Sciences, Leon County Urban League, Leon County National Association for the Advancement of Colored People, the Charmettes, Inc., and Delta Sigma Theta Sorority, Inc.
Lisa J. Lang

Objective
To obtain a position in an administrative environment requiring strong analytical communication and organizational skills, while offering professional development opportunities as well as growth.

Experience
2001 – Present  Florida A&M University  Tallahassee, FL
Assistant Director
- Assist the Director in the administration, direction and supervision of the NASA, and the Ph.D. Prep Program, which includes review, planning, and research.
- Serves as liaison with participating institutions in the Ph.D. Prep Program.
- Recruit prospective students majoring in engineering and the sciences.
- Main a student tracking system on program participants.
- Assist in the preparation of required reports and preparation of proposals.
- Provide general oversight of the services delivery system for program scholars.
- Keep the Director informed and make recommendations for program improvements.
- Seek external funding to support and enhance program activities.

2001  Florida State University  Tallahassee, FL
Adjunct Faculty (College of Human Sciences)
- Taught Family Relationships: A Life-Span Developmental Approach. The objectives of the course is to help students understand families and interpersonal relationships in a changing society from a variety of conceptual frameworks; to understand human behavior within a variety of social networks, and to understand their own ways of relating to other individuals and systems.

1991 - 2001  Florida A&M University  Tallahassee, FL
Coordinator of Administrative Affairs/Budget Analysis
- Assists the Dean in initiating, developing, and maintaining graduate programs of high quality. Assists in the preparation and administration of the annual operating budget, as well as managerial and administrative decisions for approval/disapproval of admissions, fellowships, assistantships, matriculation fee waivers, o/s tuition waivers, thesis/dissertation incentive awards, and stipends to eligible graduate students (totaling over $3,000,000.00). Assists in providing administrative direction, management, and coordination of activities between the Small Business Development Center, and the TRIO Programs, with the Office of the Dean. Performs special assignments, research, and report preparation. Serves as recorder of the Graduate Council, which acts as an advisory and review body on matters of policy, procedures, and regulations directly concerned with graduate admissions, instruction, research, and other, related areas. Serves as recorder of the Graduate Council, which acts as an advisory and review body on matters of policy, procedures, and regulations directly concerned with graduate admissions, instruction, research, and other, related areas. Serves as recruiter for the School of Graduate Studies. Attends professional meetings and conferences. Attends professional meetings and conferences. Serves on the Faculty and Staff.
Scholarship Endowment Fund Committee, as well as the University Affirmative Action Committee as a liaison officer for the School. Supervises graduate and undergraduate students. Coordinate and plan meetings, orientations, conferences, and special events as required.

Fall 2000, 1991-1989  Florida A&M University  Tallahassee, FL
Adjunct Faculty (College of Education)
- Instructed Keyboarding & Document Processing in Microsoft Work to teach student’s basic skills and techniques of formatting to include information system inputting.

Education

2003  Florida State University  Tallahassee, FL
- Doctor of Philosophy  College of Human Sciences

2002  Harvard University  Cambridge, MA
- Completed the Graduate School of Education’s Management Development Program.

1997, 1998 & 1999  University of Kentucky  Lexington, KY
- 64 Credit Hours  College Business Management Institute (CBMI)

1997  Florida A&M University  Tallahassee, FL
- Master of Science  College of Education

1988  Florida A&M University  Tallahassee, FL
- Master of Applied Social Science  College of Arts & Sciences

1981  Florida A&M University  Tallahassee, FL
- Bachelor of Science  College of Education

Interests

Enjoy working with those who are in need or less fortunate than others.
- Work with HOSPICE (Leon County)
- Work with the Outreach Ministry (Bethel Baptist Church)

Awards

University Dissertation Grant  2002
Selected to participate in Harvard’s Management Development Program  2002
Leslie N. Wilson & Florence Smith McAllister Awards  2001
University Volunteer of the Year Award  1999
University Superior Accomplishment Award  1998
University Continuous Service Award  1997
The Gabor Award for Excellence  1995
University Honors Program (Devoted & Invaluable Service)  1993
University Service Award  1992

Presentations

NCFR 64th Annual Conference, Families Over the Life Course: Bridging Research and Practice. Presentation on Coping With Chronic Hypertensive
Cardiovascular Disease. Houston, TX. November 2002.