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Understanding How Religious Practices Influence Self-Care in Black Churchgoers Diagnosed with Hypertension

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MA, Union Institute and University, 2016

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Dissertation Submitted in Partial Fulfillment

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Abstract

Religion plays an essential role in managing health; however, there is limited research on religious practices among Black churchgoers diagnosed with hypertension. This research aims to understand how religious practices influence self-care in Black churchgoers diagnosed with hypertension. The sample consisted of 21 Black men and women, ages 29 to 70 years, with a clinical diagnosis of hypertension. Participants were recruited from two local, predominately Black churches in South Carolina and administered semistructured interviews to participants. A grounded theory design was used, and the data analysis consisted of constant comparison. Two core concepts were identified. One core concept identified was Self-Care Through Religious Teaching. Participants described religious practices' influence in two typologies: (a) *God's Role* and (b) *Biblical Instruction*. Religious teachings, cultivated from religion, provided information that encouraged participants' behavior, actions, and intentions. The second core concept identified was Self-Care Through Religion. Participants described religious practices' influence in two typologies: (a) *health-awareness* and (b) *self-awareness*. Religion stimulated a sense of awareness that was demonstrated through religious practices. Participants' religion provided teachings that influenced beliefs and behavior that was demonstrated through religious practices. For these Black churchgoers, religion was a massive contributor to the influence of the self-management of their hypertension. Findings may be used for positive social change by faith-based leaders and health care professionals.

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Dedication

This is dedicated to all my for-fathers, who sacrificed their freedom, civil rights, and liberties to pursue my education. I salute those who fought before me to have my inalienable rights, which were stripped from them. This is dedicated to my children (Junia & Israel) and other future leaders, inventors, educators, and social changers.

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Chapter 1: Introduction to the Study

Introduction

Cardiovascular disease has been identified as the most significant contributor to the mortality difference between Blacks and Whites within the United States (American Heart Association [AHA], 2019). According to the National Health Interview Survey, cardiovascular disease accounts for 34% of the difference in years of life lost, with hypertension (HTN) being the most significant single contributor (Howard et al., 2018). HTN accounts for 15% of the disparity. The prevalence and severity of hypertension have caused more disability and death from myocardial infarction, stroke, and end-stage renal disease in Blacks than all other racial/ethnic groups in the United States (Victor, 2008). According to the National Health and Nutrition Examination Survey, data showed a higher prevalence among Black children than White children ages 8 to 17 years with a higher risk of developing hypertension among Black adults persisting to an age older than 75 years (Howard et al., 2019). The higher prevalence of hypertension among Blacks continues to mystify researchers and healthcare professionals, but this prevalence has been a significant contributor to disparities in life expectancy among the U.S. Black population (Ha et al., 2018).

Historically, religious involvement and various health-related outcomes were well studied in Blacks (Holt et al., 2018; Coe et al., 2013; Holt et al., 2015; Holt et al., 2017; Park et al., 2018). Religious coping and involvement have been connected to an individual's coping capabilities to significant life stressors such as cancer or other chronic illnesses (Park et al., 2018). Park et al. (2018) identified that there are positive and

negative religious coping styles as predictors of wellbeing in Blacks. Black churches are ideal channels to deliver health promotion, education, and understand the connection between religion and health-related outcomes. According to Lancaster et al. (2014), in urban Black communities, 65% to 80% of adults attend church regularly, and 55% are involved in church-related activities.

Over time, progress has been at a standstill as Black adults continue to have higher rates of hypertension, along with other diseases. Many variables have been studied to account for the disparities in hypertension prevalence in Black Americans (Fuchs, 2011; Kaplan, 2015; Spence & Rayner, 2018). However, various outcomes have accounted for differences in solutions. The purpose of this study is to understand the influences that religious practices have on the self-care of Black churchgoers diagnosed with hypertension. This study will find meaning and produce themes that will help address this phenomenon. Addressing this phenomenon will assist with the efforts of understanding racial disparities in hypertension prevalence in Black churchgoers.

Background

Hypertension in Americans

Currently, there are limited cures for many chronic illnesses faced by Americans today. HTN is a major public health concern and continues to be the leading risk factor for stroke and cardiovascular disease (Chandler et al., 2021). Still, risk factors could be managed to eliminate or decrease the onset of the hypertension epidemic. According to AHA's 2019 At-A-Glance, heart disease, and stroke statistics, coronary heart disease (43.2%) was the leading cause of deaths attributed to cardiovascular disease in the United

States, and high blood pressure contributed to 9% of deaths (AHA, 2019a). High blood pressure, also known as "the silent killer," is the most modifiable risk factor for heart disease and stroke. High blood pressure (HBP) is clinically identified as HTN, and it is estimated that 47% of adult Americans have hypertension (AHA, 2019a; Chander et al., 2021; Whelton et al., 2017, Virani et al., 2021). HBP and HTN can be used interchangeably, but a clinical diagnosis is classified as HTN.

Blood pressure is the measurement of the force against the walls of the arteries as the heart pumps through the body (AHA, 2017). Our tissues and organs need oxygenated blood to survive and function properly. When our heart beats, it assists the body's circulatory system carries the oxygenated blood throughout the body (Valtchev, 2019). The heartbeats create pressure that pushes blood through tube-like blood vessels. These vessels include arteries, veins, and capillaries (AHA, 2017). Blood pressure is a result of two forces. The systolic pressure is the first force, which occurs when the heart contracts (AHA, 2017). The contraction of the heart occurs as blood pumps out of the heart and into the arteries (Valtchev, 2019). The diastolic pressure is the second force, which is created when the heart rests between beats (AHA, 2017). The high demand on the atrial walls can become damaged, and long-term effects, if not controlled, could lead to stroke, heart failure, heart attack, vision loss, and kidney disease (Whelton et al., 2017).

This epidemic has become a national priority. The Healthy People 2020 goal was focused on reducing the percentage of adults who have HTN by 10% (Healthy People 2020, 2017). Healthy People 2030 goal is focused on improving cardiovascular health and reduce deaths from heart disease and stroke in adults (Health People 2030, 2021).

Each decade AHA develops an Impact Goal that guides its strategic plan to address public health. By 2030, The AHA strives to increase healthy life expectancy equitably, using a broader vision of health and well-being (Angell et al., 2020). The AHA aspired to reduce heart disease by 20% by the year 2020 (Anderson et al., 2017). Despite the global, national, and local call to action regarding the public health burden posed by hypertension, mortality related to HTN continues to rise and blood pressure control remains a challenge (Frame et al., 2019). HTN could be one catalyst for many of the chronic illnesses that are faced by many Americans today. Although it can lead to many diseases, if managed, it can help to eliminate and decrease these disorders. HTN can be controlled with lifestyle changes (Bolin et al., 2018). Increasing and incorporating physical activity; improved nutrition that includes more fruits, vegetables, and whole grains; and reducing stress are lifestyle changes that can help manage high blood pressure. In addition, the efficacy of lifestyle modifications such as decreasing fat and sodium consumption and weight loss in the prevention and treatment of HTN is well documented (Lancaster et al., 2014). In the lifestyle intervention, Dietary Approaches to Stop Hypertension (DASH) trial, the reduction in SBP and DBP blood pressure was comparable with those observed in drug trials (Lancaster et al., 2014). As stated earlier, there is no cure for many of these diseases, but eliminating and managing hypertension could be one or a key to decrease stroke and heart disease.

Hypertension in Black Americans

In the United States the death rates from CVD and stroke differ by various social determinants including income, age, education, location, and race/ethnicity. Blacks

experience an unequal number of deaths from heart disease, stroke and hypertension compared to Whites (Angell et al., 2020). The HTN prevalence in Black Americans is among the highest in the world (Virani et al., 2021). In 2017, the American College of Cardiology/American Heart Association (ACC/AHA) changed the blood pressure guidelines. Normal blood pressure is a systolic blood pressure (SBP) less than 120 mmHg and diastolic blood pressure less than 80 mmHg (Whelton et al., 2018). The new guidelines now define hypertension in stages. Stage 1 entails a SBP of 130 – 139 mmHg or DBP or 80 – 89 mmHg and stage 2 entails a SBP > or equal to 140 or DBP > or equal to 90 mmHg (Nassar & Ferdinand, 2018). According to the American Heart Association's 2013-2016 data, 58.6% of Black males and 56.0% of Black females had hypertension (2019). Approximately half of the diagnosed hypertension in Black males and females are uncontrolled (Cuffee et al., 2020). Results from a 2013 study identified Blacks were more likely to have resistant hypertension among adults with hypertension (Whelton et al., 2019). Adequate blood pressure control can lower cardiovascular mortality, reduce strokes, and heart failure complications. This chronic illness can be managed with medication and lifestyle changes related to nutrition, physical activity, and smoking cessation.

Amongst the Black population in the United States, the high prevalence of HTN is a significant contributor to disparities in life expectancy (Howard et al., 2018). Nevertheless, the cause for higher incidence and prevalence of HTN among Black adults compared to White adults is a phenomenon. Access to medical care, noncompliance to medication, body mass index, and salt sensitivity are some factors that are speculated to

be contributors (Ha et al., 2018). It is well documented that Blacks are prescribed more antihypertensive medications than Whites, but blood pressure control is lower (Grant et al., 2016). The lack of adequate HTN knowledge and social supports are the two most prominent factors attributed to medication nonadherence in Blacks (Grant et al., 2016). These two factors can contribute to the disproportionate rates of poor blood pressure control in hypertensive Blacks. Adequate blood pressure control can reduce cardiovascular-related mortality and provide significant cardiovascular benefits (Grant et al., 2016; Howard et al., 2018; Victor et al., 2008). There is a need to understand better the reasons that could guide efforts to prevent hypertension and reduce the difference in mortality between both populations.

The cultural factor of religion is vital in understanding self-management amongst Blacks. Culture is what connects a community and can influence one's perception of healthcare, family, medicine, and nutrition. Culture plays a role in self-management and cares for hypertension in this population (Bolin et al., 2018; Campbell et al., 2015; Moss et al., 2019;). Evidence confirms that there are associations between health and religion (Park et al., 2018). There is literature that supports the positive role religion plays in health outcomes, but there is also literature that explores the negative role. It is suggested that religiosity has beneficial effects on the attitudes, motivations, goals, social interaction, and perceptions of individuals about wellness that are associated with church attendance (Bruce et al., 2017). Researchers have suggested that people who are deeply involved with his/her religion tend to have health outcomes because their lifestyle may line up with his/her religious belief. The weight of the data determines there is a positive

association between religion and health-related issues, including cancer, heart disease, hypertension, and health-related behaviors (Coe et al., 2015).

Problem Statement

In the United States, there is a gap between the effects and complications of hypertension in Black adults and White adults. Individuals greater than or equal to the age of 18 years are classified as an adult. Forty-six percent of Black adults are affected or diagnosed with hypertension compared to 31% of Whites affected by HTN (Cuffee et al., 2020; Spence & Rayner, 2018; Landry et al., 2015). Black Americans are also diagnosed with HTN at an earlier age, with higher blood pressure levels (Grant et al., 2016; Spikes et al., 2019). Blacks diagnosed with HTN increases their chances of having a fatal stroke by 80% and are 1.5 times greater of dying due to heart disease and have a 4.2 time higher rate of experiencing kidney disease (Bartolome et al., 2016; Grant et al., 2016). The research has provided the guidelines, tools, and recommendations needed to lower high blood pressure (Bangurah et al., 2017; Carter-Edwards et al., 2018; Howard et al., 2018; Victor et al., 2018). The tools needed to increase treatment adherence in Blacks may not be adequately supplied or administered due to cultural or social factors. Multilevel interventions have been suggested for response and care to improve self-management behavior amongst Blacks with hypertension (Ephraim et al., 2014). Self-management behavior can be motivated by various factors (Barksdale & Metiko, 2010). Environment, socioeconomic status, religion, education, geography, age, and race are a few examples of factors that can drive behavior (Glanz et al., 2015). Religion is an essential cornerstone within the culture and history of the Black

community (Bangurah et al., 2017). In a study with the highest percentage of any demographic group studied, of all the Blacks surveyed, 85% stated, “religion was significant in their lives,” and 83% “consider themselves Christians” (Boyd-Franklin, 2010, p. 977). The Pew Research Center’s Forum on Religion and Public Life solidified this study by claiming Black Americans are the most religious racial/ethnic group in the US (Millet et al., 2018). These data provided evidence that supports the role that religion plays in this population.

There is evidence that suggested that individuals involved more with religion, which includes regularly attending religious services, are associated with lower blood pressure and reduced likelihood of hypertension (Bell et al, 2012; Bruce et al., 2017; Charlemagne-Badal & Lee, 2016; Fitchett & Powell, 2009). Additional research needs to be conducted that revolves around the process of how religion affects the self-management of chronic illnesses. There were significant data that supported the importance of religion in Blacks, but no research focused on how it affects self-management with hypertension in this population (Coe et al., 2015; Holt et al., 2017). Given the growing numbers of Blacks diagnosed and dealing with the complication of hypertension, it is necessary to conduct a study to explore the role religion plays and the practices used in the self-management in this population. Understanding religion in this population can help provide educators and providers with a critical component to incorporate into interventions and care. This research can provide health care professionals with a framework when developing hypertension management intervention and models specific to this population.

Purpose of Study

The purpose of this grounded theory study was to understand how religious practices influenced the self-management in Black churchgoers diagnosed with hypertension in the Southeastern region of the US. Grounded theory allowed the researcher to understand this population's experiences and perceptions of religious practices and hypertension self-management (Creswell & Creswell, 2018). This method assisted with the development of culturally based theories that explained various concepts. This approach identified themes and categories around religious practices that influenced hypertension management in Black churchgoers. The grounded theory process involved multiple stages of data collection that allowed the researcher to derive a general, theory of process, action or interaction grounded in the participant's views (Creswell & Creswell, 2018). This study used a qualitative approach. Identifying the in-depth perspective of this population has the potential to create the foundation of new theories and research. Themes, about self-care and religion, were determined using qualitative semi-structured interview questions. The inquiry helped to identify specific factors about religion that influences hypertension self-care in Black churchgoers. Research supported the need for public health workers to work with Black churches (Brewer & Williams, 2019; Brand, 2017). This research can be instrumental in the conceptual framework when developing programs, education, and interventions.

Research Questions

The following research questions were developed in an attempt to understand the influence religious practices had on self-care and health promotion. This research was

explicitly focusing on Black churchgoers diagnosed with hypertension. Identifying the influences of religious practices benefit and protect the health and quality of life for Black churchgoers diagnosed with hypertension.

1. How do religious practices influence self-care in Black churchgoers diagnosed with hypertension in Southeastern United States?
2. How do religious practices influence health promotion in Black churchgoers diagnosed with hypertension in Southeastern US?
3. What religious factors influence self-care in Black churchgoers diagnosed with hypertension in Southeastern US?

Theoretical Framework

Sufficient evidence supported the benefits of modifying lifestyles for HTN control. To understand, predict, and explain behavior, many professionals use the Theory of Planned Behavior (TBP) (Glanz, Rimer, & Viswanath, 2015). The integration of the TPB helped gather a deeper understanding of the religious practices and factors that influence Black churchgoers' actions related to blood pressure control. TPB is used to predict and explain human behavior. "The TPB hypothesizes that attitudes, subjective norms, and perceived behavioral control, predicts actual health behaviors" (Peters & Templin, 2010, p.173). Exploring the attitudes and perceived behavioral control in Blacks with hypertension was a great framework to create intervention and education to help maintain self-care.

Culture and religion are two factors that can formulate one's behavior, attitude, motivation, and normative beliefs. Katz (1960) stated that people have views because

they promote their psychological well-being. Religion is a significant cornerstone in the Black community. The 'circle of culture' represented a connection that unites individuals within the Black community and provided boundaries for culturally acceptable behavior (Peters et al., 2006). Beliefs, attitudes, and motivations are multidimensional constructions that can be generated from Black American's circle of culture. Understanding the negative and positive influences regarding self-care and HTN in Blacks can help provide a blueprint for intervention and care. Focusing on positive impacts can help to keep patients engaged while problem-solving to address the negative feelings. Blacks with HTN are aware that changing diet, increasing exercise and reducing stress could control blood pressure, but the norms for diet and food preparation were used as the dominant cause of HTN (Bolin et al., 2018). Intrapersonal and interpersonal factors that affect behavior in Black churchgoers with hypertension can be identified. Knowledge of the beliefs and attitudes carried by Black churchgoers can assist healthcare professionals and educators in providing more effective care and intervention.

Nature of this Study

The nature of this study used the grounded theory qualitative design approach. Charmaz (2014), Corbin (1994; 1998), Glaser and Strauss (1967) identified the procedures of grounded theory as the interaction rooted in the views of the participants, which involves multiple stages of collection, refinement, and interrelationships of categories (Creswell & Creswell, 2018). The grounded theory methodology enabled the researcher to study this selected population and their experience with religious practices and how it influenced the self-management of their hypertension. The Southeastern part

of the United States, specifically South Carolina, was the study setting. South Carolina is considered part of the *Bible Belt*. Populations within the *Bible Belt* self-identify as fundamentalist, meaning they literally interpret the writings from the Bible (Thomas-Durrell, 2019). In a 2016 study conducted by Barna Group to understand beliefs, practices and experiences related to supernatural healing in adults, it is reported that miraculous healing was reported more in the *Bible Belt* (South & McDowell, 2018). Due to the nature of the study, methodologists encouraged researchers to administer culturally specific interviews when working with one particular population to identify the norms, rules, and values that can help to understand people's behavior (Rubin & Rubin, 2012). For this study, the primary source of data was collected using in-depth qualitative semi-structured interviews. With semi-structured interviews, the questions were open-ended, which allowed the participant to respond freely (Rubin & Rubin, 2012). The data was analyzed by using systematic steps. Grounded theory data analysis involved generating categories of information, positioning one of the classes within a theoretical model, and finally explaining a story from the interconnection of these categories (Creswell & Creswell, 2018). Using a grounded theory approach identified the most significant religious practices and factors that influence self-care in Black churchgoers with hypertension.

Definitions

The following are the definitions of terms and phrases used in this study.

Black American: Also termed as African American and Afro-American, are Americans who are mainly of African ancestry (Encyclopedia Britannica, 2019).

Bible Belt: The southeastern and south-central part of the United States, being characterized as a population who self-identify as religious fundamentalist (Thomas-Durrell, 2019).

Religion: a Latin term that means 'to bind fast.' This refers to an institution with a recognized body of people who gather to worship, share a belief system and participate in related rituals that unite a community (Polzer & Engebretson, 2012; Shilbrack, 2018).

Black Church: a social institution with a set of historical institutions that are independently established and managed by African-Americans that represent the collectivistic culture interlaced into the lives of African Americans (Thompson, Futterman & McDonnell, 2019; Brewer & Williams, 2019; Williams, Griffith, Collins & Dodson, 1999).

God: the maker and creator of humankind; a personal, all-powerful, all-knowing, eternal, loving, spirit-composed family currently composed of the Father and Jesus Christ (John 10:30-31, 17:20-23, 1 John 3:1-2, King James Version)

Jesus Christ: God's only begotten Son, who sacrificed his life to save humanity; 'God with us'; a prophet and human being; source of the Christian religion (Matthew 1:23, King James Version; King, 2018; Merriam-Webster, n.d.)

Bible: a collection of sacred writings of the Christian religion, comprising the Old and New Testaments (Merriam-Webster, n.d)

Holy Scripture: holy books and manuscripts of the Old and New Testaments (Merriam-Webster, n.d.)

Hypertension: when the force or pressure of blood flowing through one's blood vessels is consistently too high (American Heart Association, 2019).

Systolic Blood Pressure (SBP): The phase of blood ejection from the heart during the arterial blood pressure against the walls of blood vessels (Valtchev, 2019; AHA, 2017).

Diastolic Blood Pressure (DBP): The heart filling phase from the heart during the arterial blood pressure against the walls of blood vessels (Valtchev, 2019; AHA, 2017)

Assumptions

The common assumption for this research study was the truthfulness with which the participants respond to the questions. This subject matter could be considered sensitive for some participants, and for those, it could be plausible to assume honesty. The researcher concluded that the participants' reliability will not be compromised. Researcher's bias should always be identified during the study. Creswell and Creswell (2018) encouraged researchers to provide self-reflection because it allowed for an open narrative that the readers will be able to understand. The researcher's background, culture, and religion could shape the interpretation of the findings. This research is specific to Blacks and religion, commentary regarding any arguments from the researcher could be valuable in understanding the researcher's conclusions.

Scope and Delimitations

The general rule for qualitative research is that the sample does not cease until there is data saturation (Patton, 2015). Saturation allows the researcher to know that no new information or unique insight is emerging. According to Charmaz (2014), small samples can provide significant and long-lasting data. The research question must arise through the study process and application. Sample size should increase if the researcher discovered surprising findings; pursue a controversial topic; and seek professional credibility (Charmaz, 2014). The theoretical or random purposeful sample was appropriate for this research. Random purposeful sampling is mainly judgmental because the researcher searched for samples that represent the research population (Creswell & Creswell, 2018). A theoretical sample is ideal for grounded theory because this sampling process is entirely controlled by the emerging method (Glaser & Strauss, 1967). The researcher decided what data to collect next and where to find them to assist with the emerging theory.

The priority population is Black churchgoers who have been diagnosed with hypertension in midland regions of South Carolina. Participants were recruited from predominately black churches. To be a participant in the study the following eligibility criteria were established: (1) Black American, (2) ages 25- 75, (3) clinically diagnosed with hypertension (systolic BP [SBP] > 130 mmHg and/or diastolic BP [DBP] >80 mmHg), (4) member or affiliated with a religious institution, (5) have not been diagnosed with a terminal illness, mental or psychological diagnosis or disorder.

The best source for finding participants was working with local churches. It was essential to get the pastors, senior pastors and first ladies engaged because they had a

massive influence on getting the congregation involved to enhance recruitment. Two senior pastors from local churches were contacted regarding the possibility of using their churches as a place to recruit for the study. The pastors granted permission and were briefed on the purpose, process, and responsibilities of the researcher and church. The senior pastors assisted with recruitment by making announcements during Sunday services, Wednesday Bible studies, post information in the weekly church bulletins, and place fliers within the facility. Initially, the interviews were proposed to be administered on Sundays and Wednesdays after services in a classroom located in each church. Due to Covid-19 and the stay-at-home orders many organizations closed their doors for services. The partner church doors were closed, due to the pandemic. Research participants, the church or pastors were not incentivized for assisting with the research.

Limitations

There are several foreseen limitations, challenges, and barriers related to this study. This qualitative study used a combination of data collection and analysis procedures in systematic steps. The methodological strategy for grounded theory was to conduct data collection and analysis simultaneously in an iterative process (Patton, 2015; Creswell & Creswell, 2018). A challenge to this design is appropriately developing inductive categories through systematic data analysis. The researcher used proper techniques to analyze qualitative data to determine 'true' themes and concepts. The identified topics were used to identify the 'completeness' of the understanding of the theory under investigation. A challenge the investigator faced was deciding how to appropriately collect the qualitative data (e.g., verbatim transcript, nonverbal cues, and

emotional aspects). The researcher believed that nonverbal cues were as insightful as the participant's words. The challenge would be to interpret the nonverbal cues that align with the participant's response.

Another challenge was the data collection process. This process included sampling, recruitment, and the development and pretesting of open-ended questions that identify specific religious practices that influenced hypertension self-care. Strategies used to recruit individuals were identified. The plan included ways to inform appropriate participants about the study and discuss ways to provide incentives for individuals to participate. The researcher intended to reflect on a new approach if one method of recruitment was unsuccessful. Funding and financial resources were limited for this research. Funding barriers prolonged the research process.

Study Significance

Empirical research supports three significant components that provide the framework for this research. First, Blacks have higher prevalence rates with various health disparities, which include the highest rate of hypertension (Abel & Greer, 2017). Differences in incidence, severity and effective treatment of high blood pressure have been compared in Black and White Americans (Walejko et al., 2018; Usher et al., 2018). Blacks develop hypertension at a younger age and have more complications (Bolin et al., 2018; Walkejko et al., 2018). Blacks with uncontrolled hypertension are at greater risk of experiencing stroke and kidney disease (Cuffee et al., 2020). Behavioral factors could be related to hypertension. Attitudes and beliefs shape thoughts on hypertension self-care (Campbell et al., 2015). Second, Blacks are considered to be the

most religious population, and religion is regarded as the most prominent characteristic of many Black families (Millet et al., 2018). Lastly, religion has proven to have a positive and negative role in health outcomes in Blacks (Holt et al., 2014; Park et al., 2018). Investigating these three components can be essential to identify an indirect connection. Each provides relevant data that helps to ignite the need for this current study. Additional research is needed to support the inquiry regarding how religious practices may influence self-management in Blacks churchgoers with hypertension. Research supports the importance of religion, but this study will provide information on what practices related to religion influences behavior change. This information can help address this health disparity and provide a framework for interventions, education, and programs catered to this specific population. This research can affect positive social change by providing a foundation or construct to promote hypertension management in Black churchgoers through religious practices. The impact religion has on this specific population, as a coping mechanism is well documented to the care of other chronic illness and conditions (Salsman et al., 2015; Lynn, Yoo, & Levine, 2014; Chio & Hastings, 2019; Himelhoch & Njie-Carr, 2016; Watkins et al., 2013). This study may provide additional evidence to support religion/religious practices in the care of hypertension. This research provides strategies that may contribute to positive, culturally competent interventions for Black churchgoers with hypertension.

Summary

This research addresses social change by providing data that can transform and alter the current culture of how hypertension is managed and treated in Black

churchgoers. The idea of "we are all born equal" may not be right for all. This statement is true through conception, but after entering, the world one's health outcomes are impacted by social-cultural factors including ethnicity, culture, education, wealth, environment, and religion. The division between health equity and disparity is an ever-growing issue that seems to plague the Black community. Socio environment and culture can be factors to many of these health disparities, but identifying the problem and creating a solution can help dissolve and eliminate the issue. Additional intervention and care are still needed, considering the continuous poor health outcomes in Blacks. There is relevant research for health care professionals that support religion and Blacks and its influence on health behaviors and health outcomes (Holt, Clark & Roth, 2014; Charlemagne & Lee, 2016; Bruce et al., 2017; Holt et al., 2017; Holt et al., 2018). Understanding the importance of religion could be pivotal for the development of culturally specific care, management, and intervention for Blacks and may help to address the unmet healthcare needs. There is an urgent need to develop a culturally appropriate treatment, care, and educational approaches that will affect improvements in controlling the health disparities in this population.

This study contributed to the literature by expounding on the influences that religious practices have on Black churchgoers diagnosed with hypertension. The next chapter provides a concise synopsis of the current literature that establishes the relevance to research this phenomenon. Meaningful studies related to religion, self-care, and Blacks were reviewed and synthesized to provide a rationale and justify the need for the research. Chapter 2 provides an explanation of method and finding literature sources and

an expanded version of the theoretical framework from this chapter. The literature review explains the theoretical framework and methodological contribution to how religious practice influences self-care in Black churchgoers diagnosed with hypertension.

Chapter 2: Literature Review

Introduction

Health inequalities in various ethnic groups are highly documented. There is a significant health gap between Black Americans and White Americans. Blacks have worse health outcomes and higher mortality rates concerning heart disease (Cunningham et al., 2017). Research demonstrated that understanding and identifying opportunities, challenges, and gaps could help identify this population with chronic illnesses (Long et al., 2017). Previous research (i.e., Dill, 2017; Joseph et al., 2017) has shown how spirituality and religion influence health behaviors in Blacks. This section will include literature reviews of related articles and studies on how spirituality and religion influence health behaviors, and care in Blacks. The purpose of the selected literature review was to summarize and synthesize the arguments and ideas of research supporting the theory of religion and religious practices having an influence on the self-care in Blacks with chronic illnesses.

Literature Search Strategy

This study's search strategy is supported by several related pieces of literature that formed a secure interdisciplinary connection with the study of religion, church, spirituality, culture, and health care beliefs and self-care in Black Americans. Reviewed research addressed religion and coping experiences of Black Americans with hypertension. Literature was searched in the Walden University online library using various databases including EBSCO, ProQuest Health and Medical Complete, ProQuest Nursing and Allied Health Source, MEDLINE, ScienceDirect, and PubMed. The search

terms were *hypertension, high blood pressure, blacks, African Americans, Black Americans, religion, religious, religiousness, religiosity, spiritual, spirituality, faith, health belief, health behavior, self-care, self-management, coping, coping skills, and coping strategies*. Search limits included articles published beyond 2016 and pertained to research participants older than the age of 18. Exclusionary factors included items not published in English and international studies.

Theoretical Foundation

The theoretical framework for this research is based on the theory of planned behavior. The theory of planned behavior (TPB), originally developed from the theory of reasoned action (TRA), was proposed by Icek Ajzen in 1980 (Ajzen, 1991). The theory's constructs focus on an individual's motivational factors as it pertains to performing specific behaviors. According to TPB, an individual's intentions can predict behavior. Individual behavior intentions can be determined by one's attitudes toward performing the behavior and subjective norms associated with the behavior (Glanz, Rimer, & Viswanath, 2015). An additional construct is *perceived control*, which refers to an individual's perception of the ease or difficulty of performing the behavior of interest because it takes into account situational circumstances where one may not have complete volitional control over behavior (Glanz, Rimer & Vismanath, 2015). Behavioral achievements depend on both intentions (motivations) and control, distinguished between three types of beliefs – *behavioral*, *normative*, and *control* (Idris et al., 2016). The TPB has been used to predict and explain a wide range of health behaviors and intentions.

The theory of planned behavior believes that behavior is an influence is direct intentions and that other factors such as culture and religion are not able to independently explain a person's behavior. Culture and religion are back background factors that influence behavioral, normative, and control attitude (Munniksma et al., 2011). Therefore, if culture and religion can differentiate behavior, then the matter is based on behavior, the perception of control behavior, and social norms (Idris et al., 2016). Table 1 provides an explanation for each variable in the theory of planned behavior.

Table 1

Concepts, definitions, and approach for the theory of planned behavior

Concept	Definition	Measuring Approach w/ Religious Influence
Behavior Intention	Perception on behavior possibility	What does your religion say regarding performing the behavior?
Attitude	Personal evaluation on behavior	According to your religion, is your behavior good, neutral or bad?
Subjective Norm	Confidence that certain people may agree or disagree on behavior	Do you agree or disagree that majority of churchgoers agree/disagree with the behavior?
Perception on Control Behavior	Confidence that one has uses control in performing behavior	Do you believe religion determines how easy or hard it is to care for hypertension?

Source: Glanz, Rimer & Viswanath (2015).

The key variables of TPB include normative beliefs and subjective norms, controlled beliefs and perceived behavioral control, and behavioral intentions and behavior (Roos & Hahn, 2019; Peters & Templin, 2010; Rimer & Glanz, 2005). Religion

influences can potentially mold an individual's beliefs (Idris et al., 2016). The judgment of significant others can influence an individual's perception of social normative pressures and perceptions about the particular behavior (Rimer & Glanz, 2005). The significant others can be a higher power, parents, spouse, church members, church leaders, and other family members (Idris et al., 2016). The behavioral intention is the readiness to perform a given behavior (Peters & Templin, 2010; Peters, Aroian & Flack, 2006). Religion can influence attitude toward the behavior and belief about the presence of factors that may facilitate or hinder the performance of the behavior (Idris et al., 2016). The theory of planned behavior also considers social influence, such as social norms and normative beliefs, based on culture-related variables (Idris et al., 2016). Social influences, networks, and organizations (e.g., church and family) can affect an individual's health-related decision-making behavior.

Literature Review Related to Key Variables

Several articles related to the variables of interested and methodology were selected to review. Articles included the prevalence of hypertension in Black Americans. The research included health statistics and identifying the disproportionate health gaps between Black Americans and White Americans. These articles also reflected on how religion was used to develop and sculpt Black history, culture, and the Black Church. Articles were also used to support how Blacks use religion to cope with stress and health. These studies varied in design and methodology but focused and provided support on the influence of religion in Blacks for managing hypertension.

Hypertension Prevalence in Black Americans

The American Heart Association (2019b) defines hypertension as "when the force of blood flowing through your blood vessels, is consistently too high" (n.p). In 2017, the American College of Cardiology/American Heart Association (ACC/AHA) changed the blood pressure guidelines. The new guidelines now define hypertension in stages. Stage 1 entails a systolic blood pressure (SBP) of 130 – 139 mmHg or diastolic blood pressure (DBP) or 80 – 89 mmHg and stage 2 entails a SBP > or equal to 140 or DBP > or equal to 90 mmHg (Nassar & Ferdinand, 2018). According to the National Health and Nutrition Examination Survey (2015 – 2016), 40.3% of Blacks are more prevalent of high blood pressure than Whites (Nasser & Ferdinand, 2018). Seventy-two percent of Blacks with hypertension do not have their blood pressure under control (Grant et al., 2016). This chronic illness can be managed with medication and lifestyle changes related to nutrition, physical activity, and smoking cessation.

Links to Risk of High Blood Pressure Among Blacks

There are many theories associated with the prevalence of hypertension in Black Americans. For some researchers, it remains a mystery. Some researchers and scientists attributed this phenomenon to lifestyle, socioenvironmental factors, and genetics (Bolin et al., 2018). One theory or hypothesis has been termed as the "Slavery Hypertension Hypothesis" and "African Diaspora Hypothesis." This hypothesis states that native African slaves could sustain and conserve sodium due to the harsh conditions they endured during the Middle Passage (Kaplan, 2015). These conditions included frequent vomiting, sweating, and diarrhea, which could cause dehydration. Chroniclers of slave

expeditions recorded the most common causes of death on the Middle Passage as diarrheal (the ‘flux’) and febrile disease (Wilson & Grim, 1991). Both result in salt depletion. This ability to conserve salt was a form of fatal salt-depletive disease protection (Fuchs, 2011). This hypothesis claims that due to this adaptive mechanism in addition to a high sodium diet in America, caused a higher incidence of hypertension in Black Americans. African slave descendants would consume higher salt consumption in American foods compared to foods in African.

Similarly, Wilson and Grim (1991) agree that these death-causing diseases such as diarrhea, fevers, and vomiting may have enhanced the genetic-based ability to conserve salt. This adaptation provided a distinct survival advantage over others more likely was passed down to generations of African Americans. The National Health and Nutrition recently reported that 42.8% of US-born blacks but only 27.4% of foreign-born blacks had hypertension (Spence & Rayner, 2018). This natural selection for survival supports the evidence of genetic differences and higher prevalence of hypertension among Blacks versus African residents.

Additionally, genetics and biological factors have been linked to the risk of high blood pressure among Blacks. National Institutes of Health scientist recently identified the links of genetics to the risk of high blood pressure among Blacks. Their study identified 17 variants in the *ARMC5* gene that were associated with blood pressure among blacks (National Institutes of Health [NIH], 2019). According to the researcher, *ARMC5* may assist in how the adrenal glands function with the hormones that are important for regulating blood pressure (NIH, 2019). Compared to Spence and

Rayner's (2018) research, it confirmed that Liddle phenotype is more common in Blacks. This well-known heredity phenotype results in hypertension due to sodium retention. This phenotype could be instrumental to the Black's survival during their passage from Africa to America on the slave ships. In addition to the Liddle syndrome, it is also suggested that there is more primary aldosteronism in Black hypertensive. "Aldosterone stimulates the epithelial sodium channel (ENaC) to reabsorb sodium in response to sodium depletion through activation of the renin-angiotensin-aldosterone system" (Spence & Rayner, 2018, p. 264). In summary, this evidence showed the correlation between genetics in Blacks and its link to the risk of high blood pressure.

Religion for Black Americans

Incorporating culture into care, education, and intervention could help with increased engagement and retention. Culture is what connects a community, and it can influence one's perception regarding health, religion, family, and medicine. Many populations and communities are sculpted by culture. Culture shapes values, beliefs, norms, attitudes, and motivations regarding health (Swierad, Vartanian & King, 2017). When compared, Black and White American's historical and cultural experiences differ significantly (Holt et al., 2015). Historians document Black religion originates from various regions of Africa (e.g., Cush, Egypt) and later influenced by the institution of slavery and colonialism (Carter, 2002). This "re-worked" form of Christianity provided African Blacks with a distinct characteristic and style of religion. The different Black cultural aspects and religious beliefs, healthcare professionals should be aware and conscious of these factors when providing care, education, and intervention. Spirituality

and religion are an integral part of all sociocultural systems but has been identified as an essential determining factor for Black adults when it pertains to health (Bruce et al., 2016). It is necessary to understand the cultural perspective of religion in the Black community. Religion has played a historic role. Religion became one of the most vital cornerstones in Black culture, starting from the times of slavery to segregation and discrimination.

Blacks are descendants of Africans who were forcibly and involuntarily brought to the US during the 1600s as slaves (Campinha-Bacote, 2009). As the world around them continued to be life-threatening and unpredictable, religion provided a solid foundation.

> "The Black experience in America is markedly different from that of other immigrants, specifically in terms of the extended period of the institution of slavery and the issue of skin color as a means for the dehumanization of African Americans" (Campinha-Bacote, 2009, p. 49).

During times of trouble, God is seen as a comforter and is a deliverer from unjust suffering (Musgrave et al., 2002). The American slaves communicated and expressed their struggles through religious songs. Songs included the story of their hardships, fears to God and ways to encourage each other (Hamilton et al., 2016). The songs helped to maintain a definite sense of self as a child of God, to cope with a servitude life, and to believe in the promises of a pain-free life (Hamilton et al., 2016). African slaves also learned *The Bible* through sermons. They familiarized themselves with the stories of God leading the Israelites from Egyptian bondage, Hebrew children escaping from the fiery

furnace (Hamilton et al., 2013). These scriptural passages confirmed and provided hope of God's promise of deliverance from suffering. *The Bible* communicated hope and promise to African slaves. The Black Church played a historical and spiritual role. It provided a sense of spiritual renewal and empowerment. It provided spiritual, social and physical well-being for the Black communities during the antebellum period, Emancipation, Jim Crow, Southern Migration, and Civil Rights era (Taylor & Chatters, 2010). The Black Church continues to perform social, civic and community roles and functions even today.

The family and community collectively united as they fought during the days of Jim Crow, civil rights movement and facing the hatred of white supremacy. The Black Church played a pivotal role in the development of Black communities and educational institutions (Taylor & Chatters, 2010). This action helped to create the Black traditions and developed the role the Black Church played in the communal nature of worship along with the collectivity of the church. Post-emancipation, the Black churches help find colleges and universities for Black students (Taylor & Chatters, 2010). This was the creation of Historically Black College and University (HBCU). Many of the HBCUs had an affiliation and sponsorship from religious entities. Commitment to educational attainment in Blacks was and continues to be a priority for Black religious institutions. Historically, the Black Church has been pivotal in addressing particular issues and living conditions that are detrimental to the well-being of Blacks. Blacks who attend church more than once a week live healthier and longer lives (Marks et al., 2005). The Black Church had, has and will have the ability to use its power to help Blacks.

Researchers have defined religion as a multifaceted design that encompasses specific behaviors, attitudes, and beliefs, constructed around a structured system of practices and rituals (Taylor & Chatters, 2010). Blacks define religion as "one's adherence to the prescribed beliefs and devotional practices associated with the worship of God" (Mattis & Grayman-Simpson, 2013, p. 547). Religion can refer to religious attendance, practices, or activity. Communal religious activities can promote health and increase social support (Musgrave et al., 2003). Religiosity is a framework that creates meaning for life and the sense of coping with life. Empirical research illustrates the relevance religion has in the lives of Blacks in the US. Research continues to demonstrate higher religious involvement amongst Black Americans compared to White Americans. Eighty-nine percent of Black American adults and 54% of youth either self-identify themselves as religious or identifying religion playing a significant role in their lives (Mattis & Grayman-Simpson, 2013). Seventy-eight percent of the adults attended religious services regularly; and 90% prayed, meditated, or used religious materials (Mattis & Grayman-Simpson, 2013). Prayer and stronger religious beliefs are reported more prevalent in Blacks compared to Whites. Religious coping is used more frequently in elder Blacks to manage emotional distress, and there is a correlation between low cancer incidence and risky health behaviors and religious activity (Salsman et al., 2015; Marks et al., 2005; Mattis & Grayman, 2013). It is hypothesized that the religion-health-longevity link is from the belief that with God illness can be overcome, which could have positive physiological effects (Marks et al., 2005).

Using Religion to Cope

There is much empirical research that identifies the role religion plays in the Black community. Religion may have an indirect effect on health behaviors, including self-management (Coe, Keller & Walker, 2015). For example, Choi and Hastings (2019) found that religion has been shown to increase coping conditions among African American adults with diabetes. Research by Lynn, Yoo, and Levine (2014) found that Black breast cancer survivors believed religion and spirituality helped them deal by attending religious services, comfort through prayer, and church members. Therefore, increased self-management can increase positive health outcomes. Self-management behaviors can include eating healthier, being more active, adhering to medication guidelines, eliminating smoking, and applying preventative care (Long et al., 2017). Religion and religious practices can be incorporated in self-management to influence positive health behaviors. Religious traditions can be linked to increased self-management.

Namageyo-Funa, Muilenberg, and Wilson (2015) define coping as "constantly changing cognitive and behavioral efforts to manage external and internal demands that are appraised as taxing or exceeding the resources of the person" (p. 242). Blacks identify religion to cope with chronic illness (Polzer & Miles, 2007). Blacks have been reported to "(a) report higher levels of attendance at religious services than Whites, (b) read more religious materials and monitor religious broadcasts more than Whites, and (c) seek spiritual comfort through religion more so than Whites" (Constantine, Lewis, Conner & Sanchez, 2000, p. 28). Researchers had identified Blacks as being more

religious. This information can support that religion is a choice for Blacks regarding health issues and care. One's perspective regarding life and health can be influenced by having faith and believing in God, Jesus or a higher power (Krause & Hayward, 2015). Therefore, health care professions can consider health-seeking behaviors can be influenced by religion.

Religion and religious practices can be displayed in various ways. Some religious methods include attending religious services, prayer, fasting, singing, meditating, fellowshipping with others, reading The Bible/scriptures, and listening and watching religious programs. Research suggests that religious beliefs may function in several ways to influence overall health and with coping with an illness (McAuley, Pecchioni & Grant, 2000). Depression and high levels of life stressors are identified less in those that attend church and engage in religious practices (Hamilton et al., 2017). Participants in one study identified prayer as a meaningful and valuable coping resource (Marks et al., 2005). Prayer can be done privately, in pairs or collectively in a large group. Religious Blacks reported that prayer could heal because God can cure illness (Mattis & Grayman-Simpson, 2013). In a study that explored how Black men used religion to cope with their diabetes management, seventy-five percent described that praying and believing in God was vital with the management of their diabetes (Namageyo-Funa, Muilenburg & Wilson, 2015). God's will is reflected in one's health outcomes.

Stories and parables that depict survival from The Bible is an essential aspect of religious culture. Many of the scripture passages provide meaning to human existence. For Black Christians, Biblical scriptures are "a source of religious instruction and the

communication of a promise of protection from evil situations to those individuals who adhere to the religious doctrines of sacrificing, praying and reading the word of God" (Hamilton et al., 2013, p. 179). Research support how useful reading The Bible is for individuals coping with various chronic illnesses. Historically, Blacks have used passages from The Bible as a way to promote mental health during stressful life events (Hamilton et al., 2013). Scripture can play a role in self-management. Black men with diabetes stated that meditating on the passages and scriptures from The Bible helped them cope (Namagey-Funa, Muilenburg & Wilson, 2015). Polzer and Miles (2007) provided an example of how Blacks used scripture to explain how they perceive their diabetes self-management.

According to these participants, God has created man in his image, and it is their responsibility to do all they can to take care of themselves. The body is also viewed as the Temple of God, and God holds everyone responsible for their health. These participants believed that these scriptures emphasized the importance of taking care and responsibility for one's health. The Bible is also perceived as a teaching and instructional tool. Meaning of its teachings talks about humans having a dependent relationship with God. God has given humans life, blessings, free will and common sense (Polzer & Miles, 2007). Individuals must use their will and common sense in part of taking care of themselves. Disobedience is apparent when individuals do not take care of themselves, and God disapproves. Disapproval from God may lead to consequences. Some Black women and men with diabetes believe that it is sinful to not care of one's body because it is considered a Temple of God (Polzer & Miles, 2007). Many scriptures support

responsibility for self-management. Scriptures also provide instructions and guidance on the consequences of not accepting responsibility, by expressing disobedience, punishment, and sin. Scriptural teachings also comment on God's healing power to all illnesses. Scriptures illustrate how Jesus healed the sick and gave humans authority over sickness and disease. Humans can be cured by faith and God's power (Casarez et al., 2010). This theology can cause believers to relinquish control of self-management.

Amongst older Black adults who experienced cancer, heart disease, diabetes and bereavement, religious songs strengthened and comforted this population (Hamilton et al., 2012). Religious songs, also identified as Praise and Worship, can have various functions. A religious song is a form of practice that allows for participants to demonstrate outward expression of faith, hope, praise, thanksgiving, connection to God, and to tell a story of lived experiences (past and present). Historians suggest that it is transformative in changing a person's negative mood to more of a positive and hopeful spirit (Hamilton et al., 2017). It is based on a person's beliefs and values. Hamilton et al. provided data that detailed older African Americans using songs of Thanksgiving and Praise as a way to cope with their own experience with life-threatening illness. For young and middle-aged Black men and women, religious songs that provide guidance was identified as being frequently used (Hamilton et al., 2017). Religious songs can guide participants on how to think about the current situation and on how to redefine or reframe it. The words can express encouragement by reassuring that the person is not in the situation alone. Hamilton et al. describe how survivors of catastrophic events have faith that God will help them endure unpleasant life events. Reliance on God can comfort

those during life-altering events. God is with them by supporting and guiding them with love and grace.

Religion is not only seen in this adult population but also youth. Religion and spirituality ignited a resiliency factor for Black youth at a high risk for poor adjustment (Humphrey, Huges & Holmes, 2008). (Dill (2017) conducted a study to gain a better understanding of how young Blacks, living in stressful environments and communities, use religion to cope. An environment that was labeled as "ghetto" and "hood" was identified as a place to study this population. Through this project, Dill (2017) explored the different dimensions of resilience amongst the youth living in a high-risked area. Working with the local youth center, Dill was able to collect data through participant observation and interviews. The youth center provided various youth and after-school programs and classes. Dill's data analysis supported the importance of religion for these youth. Like other researchers, that data showed that prayer, faith and giving back were religious practices these youths used to cope with stressors. Dill's research can help teachers, counselors, therapists, and health professionals get a better understanding of the importance of religion when working with this population. Long-term actions could include incorporating spirituality into programs, classes, and care to help young Blacks deal with stressors.

God's Role in Black American Spirituality

The cultural factor of religion is vital in understanding self-management amongst Blacks. Evidence confirms there are associations between health and religion (Park et al., 2018). There is literature that supports the positive role religion plays in health

outcomes, but there is also literature that explores the negative role. Theory and research suggest people who are deeply involved with his/her religion tend to have health outcomes because their lifestyle may line up with his/her religious belief. The weight of the data determines there is a positive association between religion and health-related issues including cancer, heart disease, hypertension, and health-related behaviors (Coe, Keller & Walker, 2015).

Religion can connect one to God. Religious theories suggest that belief in God provides hope (Namageyo-Funa et al., 2015). "God is defined as the maker and creator of humanity. Sin separated man from God, but Jesus Christ, the only begotten Son of God, and his death on the cross brought man back to God" (Terrell, 2001, p. 92). Many Blacks view God as the center in their overall belief system about health (Millet et al., 2018; Himelhoch & Njie-Carr, 2016; Namageyo-Funa et al., 2015; Lynn, Yoo & Levine, 2014; Bhattacharya, 2013; Polzer & Miles, 2007). This perception of having a supportive God can promote good health and health management. Black women with HIV proclaimed that God is with them, which helped them deal with their illness (Himelhoch & Njie-Carr, 2016; Casarez et al., 2010). God helped women control their diabetes, and God plays a central role in leading the lives of older blacks with diabetes (Polzer & Miles, 2007). Black men with diabetes talk and pray to God for help because this provides them with the strength to cope and manage challenging situations (Namageyo-Funa et al., 2015). This internal strength has the propensity to encourage self-management. Hope, faith and having a relationship with God can trigger a change in behavior. The thought of just "being alive" is a testament to many regarding God's role

in self-care. In a study with black men with diabetes, fifty percent believed that God's mercy and love are shown because He wakes them up every morning (Namegoyo-Funa et al., 2015). The experience has brought them to closer to God.

Older, yet similar, research was explored in African Americans diagnosed with type 2 diabetes by Polzer (2006, 2007) and Miles (2007). The research administered by Polzer and Miles provided data that helped to identify how spirituality and religion influences self-management in African Americans with type 2 diabetes. Through this research themes were identified to answer the question regarding the inquiry. Polzer's research has indicated the idea of "turning things over to God" (2006). Many participants highlighted how turning over their problems, situation, and illnesses to God is more manageable because it can eliminate stress, worry, and anxiety (Namagey-Funa et al., 2015; Polzer, 2006; Polzer & Miles, 2007). This idea involves the individual relinquishing his or her illness and outcomes to God while continuing self-care. The individual accepts the responsibility for the chronic illness self-management. This is more of a collaborative effort, where God and the individual take on responsibility. Polzer and Miles (2007) described this relationship has to be dynamic because God and the participant worked jointly together. God provides a supportive "behind-the-scenes' role. Bhattacharya's (2013) research, which involves 31 Black diagnosed with diabetes, supported the Polzer and Miles findings. Twenty-five percent of these participants trusted that God helps them and guides them with the management of their diabetes. In this conceptual framework, work and power are evenly distributed. Positive outcomes resulted were due to work performed by the participant with the support from God.

In a qualitative study with 39 Blacks, aged 42-73, Polzer and Miles (2007) identified two additional typologies regarding God's role in diabetes self-management. The two new typologies are "Relationship and Responsibility: God is in Forefront; Relationship and Relinquishing of Self-Management: God is Healer" (Polzer & Miles, 2007, p. 185). Within the concept of God being in the forefront describes the participant playing a submissive role and yielding to God's authoritative power. The submission is lead from the faith and trust that God will take care of the illness. Faith could take the front seat to self-management or religious practices. It was believed that self-management was necessary because it would be unknown if and when God would heal them. This group described God's role as more authoritative, and He played the leading role. In a similar study, Polzer (2006) observed Blacks, with diabetes, and how his or her health care provider's spirituality played a role in self-management. The participants viewed the health care providers as God's utensils and instruments. They believed that God gave health care professionals the intellect, knowledge, and capabilities to provide the care (Polzer, 2006). The last theme identified by Polzer and Miles (2007), was God being a healer. People that fell under this category relied on the faith that God would heal them from diabetes. The underlining thought was that self-management was not needed because God would cure them of diabetes (Polzer & Miles, 2007). The faith involved not "claiming" the disease and that he or she is already healed. The idea is to surrender to God's will because they are helpless to control their diabetes (Bhattacharya, 2013). The body can heal itself with the miracles and healing power of God. All constructs revolve around a relationship with God and what role He plays in self-

management. The research done by Bhattacharya, Polzer, and Miles, and Polzer provides a theoretical understanding of how religion affects self-management in Blacks with diabetes.

The Black Church

Well-documented evidence shows the powerful influence and the central role the Black church played in the lives of Blacks throughout history. The success of the Black church can be attributed to the services provided to their community, and it was founded, controlled and lead by Blacks themselves (McAuley, Pecchioni & Grant, 2000). This opportunity allowed for the culturally unique creation of their communities and to worship in their way. Historically, the Black church has been identified as being multifaceted. During the US slavery period, the Black Church served as a place for spiritual worship, place of refuge for Africans escaping slavery, and political activities (Frame & Williams, 1996). Blacks were able to institute separate churches after Emancipation. Responding to the needs of the community the Black Church birthed new schools, insurance companies, banks, and low-income housing (Brand, 2017). It also ignited advocacy efforts for politics and social justice. It encompasses a place of refuge and healing while providing hope, spiritual guidance and social support for Blacks (Brewer & Williams, 2019). Some scholars labeled Blacks as “super-churched” because they were known to attend church on Sundays plus other days during the week (Barnes, 2014). The Black Church could be the key to unlock the answers on how to help optimize the health among Blacks.

Collaborative Effort in Health Promotion

Blacks were forced to receive dehumanizing, incompetent, and abusive treatment from the government and medical professionals. From 1932 to 1972, the Venereal Disease section of the Public Services activated the Tuskegee Syphilis Study. The government enrolled 399 Black men from Macon County, Alabama who had late stages of syphilis (Laws, 2018). The purpose of the research was to follow the untreated men until death to conduct autopsies. The men in this "study" were neither informed of their syphilis diagnosis nor were they aware they were not being treated. This 40-year experiment shocked the Black communities along with the nation, leaving room for distrust within the government and health care system. Also, poorly equipped medical care, no transportation and lack of medical insurance contributed to the poor physical health in Blacks (Mattis & Grayman-Simpson, 2013). The Tuskegee Syphilis Experiment triggered a mistrust between Blacks and the health care system. Services, research participation and health programs offered in traditional health care systems are less likely to be attended by Blacks (Brand, 2017). This lack of involvement ignites the need for a non-traditional approach. The approach must be trustworthy, culturally sensitive and flexible for rural populations. The Black Church is a place where individuals can feel safe. It is a place where communities can share similar morals, interests, values, hardships, and support (Brand, 2017). The Black Church provides a unique type of support by providing the inclusion of culture, belief, customs, traditions, and behaviors. This type of environment is an ideal setting for the successful

implementation of health promotion, education, and intervention. These attributes can help remedy the gap in health disparities and inequality faced by the Black community.

The Bush Administration, in 2001, established the White House Office of Faith-Based and Community Initiatives, which allowed for religious institutions and faith-based organizations (FBO) the opportunity to receive resources and support to help provide health promotion to their communities (Rowland & Issac-Savage, 2014). This initiative opened the door for Black Churches to collaborate with public health agencies to provide community health intervention, programs, and education. According to Brewer and Williams (2019), the Black Church, when collaboratively working with health agencies, has been victorious in promoting positive health behaviors. Outcomes for faith-based health promotional programs for Blacks there was a significant reduction in cholesterol, weight, blood pressure and an increase in physical activity (Bland, 2017). Interventions also included a decrease in smoking cessation, fruit and vegetable consumption, and cancer screenings in Blacks (Odulana et al., 2014). These investigated programs within faith-based organizations focused on cancer, physical activity, cardiovascular health, chronic disease prevention, and maintenance. Some examples include Faithful Families, an initiative that promotes healthy eating and physical activity to state and local levels by building a culture of health (Brewer & Williams, 2019). The Balm in Gilead, Incorporated hosts the Healthy Churches 2020 National Conference which harnesses on the strength of FBO coalitions to combat the health disparities in Blacks. These initiatives' goals are to unify faith with health while linking leaders and members of Black FBOs to public health agencies and institutions.

Black Church-Based Blood Pressure Interventions

Research that addresses the rationale and design of blood pressure control interventions to reach Blacks have been tested. Researchers understand the significant public health problem among blacks and have tested lifestyle-changing interventions in church-based settings (Lancaster et al., 2014; Skolarus et al., 2018; Carter-Edwards et al., 2018; Bangurah, Vardaman & Cleveland, 2017). Each intervention design addressed a gap in the literature that focused on an intervention targeting blood pressure control among blacks in church-based settings. The evidence from studies provides essential details on the rationale, outcomes, limitations, and conclusion for interventions within this specific population and setting.

The various interventions to improve hypertension used different approaches and frameworks to address gaps. Bangurah, Vardaman, and Cleveland's (2017) study examined the efficacy of behavioral and lifestyle interventions on hypertension control in a predominantly Black church congregation in northwest Georgia. The lifestyle interventions for Banguarh, Vardaman, and Cleveland's study included the restriction of sodium and an increase in physical activity. A nurse-led the 4-week diet/exercise intervention program. The sample criteria were adults ages 55 years and older, diagnosed with hypertension, or taking oral antihypertensive medications. The intervention included face-to-face group counseling and evidence-based educational materials on reading food labels, low sodium food selection, physical activity, blood pressure measurements, and pre/post surveys. Various validated tools were used to measure sodium intake and physical activity levels. Bangurah, Vardaman, and Cleveland's quantitative study

determined that there was a significant decrease in dietary sodium consumption and an increase in physical activity levels post-intervention for participants.

The Faith-based Approaches in the Treatment of Hypertension (FAITH) trial was the cluster-randomized trial that evaluated the effectiveness of faith-based therapeutic lifestyle change intervention versus health education control on blood pressure reduction among hypertensive black adults (Lancaster et al., 2014). Findings from this study provided an alternative and culturally appropriate model for hypertension control. Carter-Edward and colleagues (2018) did a community-based participatory research pilot study that explored multilevel perceptions and strategies for developing future faith-based organization blood pressure interventions for young black men. Strategies were identified that could help design future programs. All studies were useful in proving the effectiveness of Black church-based hypertension interventions. The research listed above provides justifiable outcomes that support the need for interventions for this specific population and setting. However, none included the aspect of religion or how religious practices influence hypertension self-care, nor does it include a component of religion or religious practices within the intervention.

Summary and Conclusions

There is a lack of research that focuses on religious practices in Black churchgoers with hypertension and how it influences self-care. Literature supports the idea that religion has the potential to complement self-care in Blacks (Dill, 2017; Millet et al., 2018; Park et al., 2017; Salsman et al., 2015; Himelhoch & Nji-Carr; 2016; Yoo & Levine, 2014). Religion has been identified as being a vital role in the Black community

(Brewer & Williams, 2019; Brand, 2017). The idea of religion influence may be increased for Black churchgoers. Religion and religious practices could provide positive health outcomes and provide a better understanding of what role it plays in the self-care of Black churchgoers diagnosed with hypertension. The literature identified various religious practices used for coping in Blacks (Hamilton et al., 2017; Hamilton et al., 2013; Humphrey, Huges & Holmes, 2008).

This study can address social change by providing essential data to help understand how religious practices influence self-care of hypertension in Black churchgoers. The data that emerges from this research may be instrumental in developing interventions and best practices to improve hypertension self-care in this specific community. Clinical and educational implications determined from this study can be essential resources in self-management. Education and intervention attempts should be made to promote an individual's beliefs. Research shows that there is a relationship between an individual's health beliefs and their health behaviors (Khorsandi et al., 2017). The overall goal for healthcare professionals should be to see higher health outcomes in patients and communities. Getting to the core of why one group of people are less healthy than another group is the journey that all healthcare professionals need to be focusing on. If health educators and health care providers, from assessments, find that religious practices are vital in patients, they can encourage these individuals to use these practices to provide strength and motivation to take care of themselves.

Further research can provide a foundation or framework to use in hypertension education and intervention for Blacks, especially those who attend church. No previous

study has addressed how religious practices impacts self-care in Black churchgoers diagnosed with hypertension. The qualitative grounded theory study aims to narrow the gap in the literature regarding religious practices and the influence it has on self-care in hypertensive Black churchgoers. The method section provides the methods and procedures used to identify how religious practices influence the self-care of Black churchgoers diagnosed with hypertension.

Chapter 3: Research Method

Introduction

This study's purpose was to explore how religious practices in Black churchgoers diagnosed with hypertension played a role in hypertension self-care. This chapter identified and validated the research design, which best answered the research question. It also discussed the research methodology in adequate depth to facilitate the needs, threats, validity, ethical issues, and fidelity of this investigation.

Research Design and Rationale

The purpose of this grounded theory study was to understand how religious practices influenced the self-care in Black churchgoers diagnosed with hypertension in the Southeastern region of the US. Grounded theory allowed the researcher to understand this population's experiences and perceptions of religious practices and hypertension self-management. Grounded theory allowed for themes and concepts to emerge from the research. Founded by Glaser and Strauss (1967), its inception was developed during the questioning with assumptions of positivism. This inquiry led the way that provided a "standard" approach for qualitative research. Grounded theory allowed for theories, themes, and concepts to emerge from comparative analysis to explain what has been researched (Patton, 2015). This method was suitable for this research. The grounded theory approach allowed for identified themes and categories around religious practices that influenced hypertension management in Black churchgoers. The in-depth perspective of this population potentially created the foundation of new theories and research.

Role of Researcher

The primary role of the researcher was the data collection instrument, she intently took notes and any other relevant data needed from participants (Patton, 2015). The researcher had the responsibility to set the agenda by determining which questions to ask, which questions not to ask, and identified which items are essential. The research question was linked to the method chosen and the type of analysis rationale applied (Saldana, 2016). The researcher understood the population and used the appropriate analysis methods and theoretical constructs to help provide rich data for the phenomena (Rubin & Rubin, 2012).

Qualitative interviewing is a conversation in which the interviewer listed to the responses attentively (Rubin & Rubin, 2012). The role of the interviewer was to lead a conversation in which the participant felt comfortable enough to talk about their experience (Creswell & Creswell, 2018). The interviewee guided the participant to explore a deeper understanding and perception of their experience (Rubin & Rubin, 2012). Characteristics of a successful interviewer are knowledgeable, attentive, respectful, and organized (Patton, 2015; Rubin & Rubin, 2012). The interviewer indicated that she is there to learn from the respondent's experience and reactions and engaged people in a problem-solving process by emphasizing how valuable their views are (Chrzanowska, 2002). These characteristics provided comfort and trust to the interviewee, which led to establish a good relationship (Rubin & Rubin, 2012).

As a Black health care professional, the researcher's motivations, beliefs, and experiences influenced the initiation of the current study. The researcher's bias was

identified during the study. Creswell and Creswell (2018) encouraged researchers to provide self-reflection because it allowed for an open narrative that the readers would be able to understand. The researcher's background, such as culture, history, and religion, had the potential to shape the interpretation of this study's findings. This research was specific to Blacks and religion; the researcher's comments and notes regarding reported assumptions were valuable in understanding the researcher's conclusions.

Methodology

This chapter identified and validated the research design, which best answered the research question. It committed to discuss the research methodology in adequate depth to facilitate the specific population, sampling, data collection process, tools, and analysis. Appropriate credibility, dependability, and confirmability strategies were described to address issues of trustworthiness. The chapter concluded with a description of ethical procedures and concerns related to data collection and recruitment.

Population and Sampling

The participants for this study were Black males and females over the age of 18, living in Southeastern US, who were members or affiliated with a predominantly Black church and diagnosed with hypertension. In addition, participants have not been diagnosed with a terminal illness, mental or psychological diagnosis or disorder. This population was identified for this research because according to AHA's 2019 Statistical Fact Sheet, among Blacks age 20 and older, 58.6% of males and 56% of females had high blood pressure. In addition, religious faith, mediation, and prayer are used to by many

Black Americans to cope with stressors caused by various chronic illnesses (Snodgrass, 2014).

Sampling Strategy

Two predominately Black churches, with approximately 150 parishioners at each location, were identified as a place to recruit and administer interviews. The primary source of data was collected using semi-structured open-ended interviews. The interviews allowed the researcher to key in on the research question, to interview several individuals to reach saturation, estimated to be between 20 to 30, combined, from two different predominantly Black churches. Appropriate sample was not identified for grounded theory. According to Thomson (2011), a content analysis was completed on one hundred grounded theory method articles, and the finding indicated that the point of theoretical saturation could be affected by the scope of the research question, the sensitivity of the phenomena, and the ability of the researcher. These findings also showed that the average sample size was twenty-five (Thomson, 2011). The plan for this research was to reach a maximum of twenty interviews with the intentions of fully developing patterns, concepts, categories, properties, and dimensions of the inquiry. The grounded theory method helped develop culturally-based theories that explained relationships between various concepts.

The general rule for qualitative research was the sample does not cease until there is data saturation. Saturation allowed the researcher to know that no new information or no new insight is emerging. According to Charmaz (2014), small samples can provide significant and long-lasting data. The research question must arise through the study

process and application. The sample size can increase if the research discovers surprising findings; pursue a controversial topic; and seek professional credibility (Charmaz, 2014). The theoretical or random purposeful sample was appropriate for this research. Random purposeful sampling is mainly judgmental because the researcher searched for samples that represent the research population (Creswell & Creswell, 2018). A theoretical sample was ideal for grounded theory because this sampling process is entirely controlled by the emerging theory (Glaser & Strauss, 1967). The researcher decided what data to collect next and where to find it to assist with the emerging theory.

The priority population was Black churchgoers diagnosed with hypertension in the midland regions of South Carolina. Participants were recruited from predominately black churches. Participants met the following inclusion criteria: (1) African American, (2) ages 18 and older, (3) clinically diagnosed with hypertension, (4) member of or affiliated with a predominately-Black church, (5) have not been diagnosed with a terminal illness, mental or psychological diagnosis or disorder. The criteria helped to identify the target population that corresponded to the entire set of subjects with characteristics that correlates to the research. A partnership was established between the researcher and two predominantly Black churches in the midland region of South Carolina. The researcher met with both senior pastors and provided background and information regarding the study itself and the roles each organization played. Both pastors agreed that recruitment and interview administration could be held at their locations. Previous researchers identified pastors from this specific population as the "gatekeeper" or "shepherd" for the "flock" of congregants and were fundamental to

health-related changes (Bangurah, Vardaman, & Cleveland, 2017). The pastors granted permission and were debriefed on the purpose, process, and responsibilities of the researcher and church. The pastors were also provided a copy of the participant consent form (Appendix A), letter of participation (Appendix D), and recruitment flier (Appendix C) to review, provide feedback, and approve. The senior pastors assisted with recruitment by making announcements during Sunday services (Appendix F), Wednesday Bible studies, post information in the weekly church bulletins, and place fliers within the facility. The researcher agreed to be available for educational purposes for inquiring congregation members. Both pastors gave the researcher the ability to work with their church leaders to assist with other logistics, building and room access, or possible unforeseen needs. During the pandemic's stay-at-home orders, church services and bible studies were delivered virtually. The pastors made announcements and shared the flier through email and virtual services. Interviews were intended to be administered on Sundays and Wednesdays after services or any available days in a private classroom located in each church. Due to the COVID-19 pandemic, only 2 interviews were administered face-to-face. Church services were canceled, and the researcher did not have access to the church. The two face-to-face interviews were administered in the safety of the interviewee's homes, while adhering to the CDC COVID-19 guidelines. Majority of interviews were done via teleconference or virtually.

Instrumentation

The goal was to explore the role religious practices played in self-care in this specific population. Cultural interviews were an appropriate route for this interview style.

Rubin and Rubin (2012) described cultural interviews as a way to understand the norms and values that formulate a person's behavior or traditions. It was the goal of the researcher to understand what role religion played in Black churchgoers with hypertension. Rubin and Rubin supported the idea of looking for terms and phrases with cultural studies (2012). The researcher studied other articles that focused on phenomenon similar to this specific study to generate ideas for interview questions. Chin et al. (2000); Polzer and Miles (2005); Namageyo-Funa, Muilenburg, and Wilson (2015); Polzer and Miles (2007); and Casarez, Engebretson, and Ostwald (2010) all provide interview questions from their research into their published articles. The researcher used these questions from the various researchers to frame and design the interview questions for this research. Charmaz (2014) encouraged the use of intensive interviewing for a grounded method approach. The researcher created elicitation interview questions (Appendix B) that align with the theoretical framework. For the theory of planned behavior, it was valuable for the researcher to elicit interviews to probe both the positive and negative attributes and features of the behavior of interest (Glanz, Rimer, & Viswanath, 2015). Using grounded theory as a method required the researcher to think about analytic properties while listening to the participant's responses. These questions were open-ended, direct, shaped, yet developed, and paced and unhindered (Charmaz, 2014). Culturally intensive interviewing questions were developed for this specific research sample (Appendix B).

The researcher received letters of participation from the senior pastor and first lady of Calvary Baptist Church in Blythewood, South Carolina, and the senior pastor of

Oak Grove Baptist Church in Pontiac, South Carolina (Appendix D). Informed consent was delivered to all participants involved in the study (Appendix A). Obtaining informed consent from research participants provided an honest, open line of communication between the two parties (Ravitch & Carl, 2016). Participants provided vital information regarding the study, and a strict data collection process was administered to gain the participant's trust. It was the job of the researcher to educate the participants regarding the purpose, procedures, risk, and benefit before research involvement (Rubin & Rubin, 2012). The researcher provided the opportunity for study participants to discuss any questions or concerns regarding the research. Privacy and confidentiality were preserved for all research participants. Study participants were visual and/or audio-recorded with a recording device. The researcher wrote down data (notes, responses, observations) during the interview. After each interview, the researcher recorded all data into a Microsoft Excel spreadsheet (Appendix E), which allowed the researcher to record the responses from the participant and record the researcher's observations and notes.

Memos, Journals and Observation

According to Charmaz (2014), memo writing is a critical step between data collection and writing because it allows the researcher to stop and analyze the ideas about codes during the moment. It helped find the usefulness of the group and assist with practical implications. The grounded theory method encourages researchers to memo (Charmaz, 2014). This methodology also supports having a research diary. Early memo writing and journal recordings have been administered because the researcher wanted to ensure the research was analyzed from a world's view and not personal view or opinion.

It can sometimes be hard, as a researcher, to research his or her professional world. The situation could question the way data is interpreted, interviews administered, and other components. Verbatim interpretation is ideal for data collection, but also including body language, voice projection, and facial expressions can be vital data. The survey questions (Appendix B) have been organized, so the researcher can memo while interviewing. Nonverbal behavior is valuable and reliable data, as well (Halcomb & Davidson, 2006). It is the researcher's goal to record observations while administering the interview. This process will allow the researcher to stay engaged with the interview and to interpret the data more deeply.

Procedures

Participation and Recruitment

Research participants was the primary data for this research. Research involving human subjects has engendered controversy for decades (Sade, 2017). These participants volunteered information regarding individual beliefs and actions on this topic. The researcher’s inquiry was constructed by the response of an individual or group of individuals. Participants are more likely to provide honest answers when their identity is not going to be exposed. Confidentiality and privacy are essential in research for both parties. The current research criteria include Black males and females who are currently affiliated or members of a predominately Black church who have been diagnosed with hypertension. Recruitment locations and fliers (Appendix C) were finalized and approved by Walden University’s IRB in March of 2020. Church leadership agreed to allow the researcher to come and speak to the congregation during Sunday services, Bible study,

and other church functions as needed. The researcher intended to be visible during regular services by having a station in the church lobby, so interested participants could gather information regarding the study and speak directly to the researcher. Due to the COVID-19 pandemic, the two community churches closed the doors of their churches. All face-to-face gatherings, services and functions ceased until further noticed. The researcher's goal was to recruit by face-to-face interactions with the intention of building a rapport with congregation members. The researcher never had the opportunity to build a rapport face-to-face with many of the congregation members but was able to work with the pastors to solicit members through other avenues. The senior pastors were able to disseminate recruitment fliers via email and virtual services.

The researcher developed a contingency plan if recruitment results were too low. The researcher identified two other local predominately Black churches to recruit from possibly. The researcher intended to interview an overall minimum of 20 participants. Through church recruitment, word-of-mouth, and referrals the researcher was able to reach the minimum goal of 20 participants. Twenty-one participants were interviewed. Word-of-mouth and referrals were the most effective strategies for this study.

Data Collection

Data from individual face-to-face, virtual, teleconferenced semi-structured interviews were collected. Videoconference or face-to-face interviews were options for willing participants if scheduling should become a problem. For participants who chose videoconference to administer the interview, they needed to have access to a computer, tablet, or other device to communicate at the same time. The researcher conducted

interview administration, data collection, and analysis. To prepare for the interviews, the researcher printed out the *Interview Guide* (Appendix B) and had audio recording devices ready, so it would not take any time away from time allocated for the interview. All in-person interviews took place in private locations agreed upon by the interviewee, to eliminate distractions and to provide privacy. The researcher adhered to CDC COVID-19 guidelines while administering the interviews. The researcher's goal was to make sure that the participant felt safe and comfortable. The interview process for each respondent took approximately 25 to 30 minutes. The researcher used a recording device to record participants' responses for both in-person and telephonic interviews. All video conference call's audio and video were recorded and stored. The *Interview Guide* (Appendix B) contained 11 questions that collected demographic and background information and had an additional 12 open-ended questions geared around religion and blood pressure. The open-ended question elicited responses related to experiences of religious practices, hypertension management, and the correlation between religion and hypertension. Participants had the ability to exit the interview at any time if they deemed it necessary. Once the participants had answered all 12 open-ended questions along with any follow-up questions, the researcher opened the floor to the participant to ask the researcher any questions or to provide any additional information pertaining to the research. That was the exit process for the participant, but the researcher collected the participant's contact information if there were any concerns or clarifications needed with the participant's responses.

Data Analysis Plan

During data analysis, interview audio was exported into an app called *Transcribe*. The *Transcribe* app allowed the researcher to upload the audio file into the app automatically. There was not one hundred percent complete accuracies with the transcription, but the process was straightforward. Also, due to the inaccuracy of the transcription, the researcher cross-referenced and edited the transcripts manually. The cross-referencing allowed the researcher to discover misinterpretation and eliminated content. Manually transcribing the data into a spreadsheet helped with validity and reliability (Saldana, 2016). The verbatim transcription, researcher's notes, and observations were recorded into the *Interview Transcribe Data Collection Template* (Appendix E), which was created in Microsoft Excel. Microsoft Excel was an ideal software to collect, store, and export information. Microsoft Excel allowed the researcher to create columns to collect and to assist with coding. Additionally, the researcher used *NVivo 12 Plus* to import and store the research data. *NVivo 12 Plus* allowed for organization and analysis to open-ended survey responses (Saldana, 2016). The manageable and comprehensive software provided the ability to organize, analyze and provide sentiment analysis.

Qualitative data analysis can be cumbersome and time-consuming (Patton, 2015). Time management was vital for the qualitative researcher to code and analyzes all the data. The data crosschecking and referencing allowed the researcher to get a better insight into data interpretation. This forced the researcher to hear the responses differently, inquire more, and ask questions regarding the answer. The process allowed for a broader

understanding of data and created a pathway for emerging concepts and themes. The grounded theory method is considered ‘iterative,’ which forced the researcher to move back and forth with data collection and analysis (Charmaz, 2014). When coding words or short phrases, the data can symbolically be assigned as a summative, a summary, or language or as visual data (Laureate, 2016). These words or phrases captured a meaning attributed to another source. The process of coding identifies a feature of a piece of text to see if there are similar features from another source (Saldana, 2016). Coding can come from various mediums, including notes, journal entries, pictures, videos, interviews, and transcripts. For this specific study, coding from the semi-structured interviews were administered with the intention of doing a thematic analysis. Thematic analysis identifies, analysis and interprets patterns of meaning or ‘themes’ from data (Charmaz, 2014).

With the grounded theory approach, there was a process called ‘iteration,’ which the researcher continuously moved back and forth between the data collection and analysis (Charmaz, 2014). Grounded theory is a continual comparative analysis. Saturation was completed when all new ideas and concepts were found. There are three levels of coding for grounded theory data analysis. Open coding was when the researcher breaks down or segments the data into preliminary categories. The researcher used the open coding to identify codes that were linked by a line, a sentence, text, or phrase to help understand religious practice’s influence on self-care. Axial coding followed the open coding and started breaking the groups into themes. Themes are summary statements, causal explanations, or conclusions that offer interpretations of why something happened, what something means, or how the interviewee feels about the

matter (Rubin & Rubin, 2012). The researcher then used the religious practice influences codes identified from the open coding and connect them to each other by creating categories and concepts. With selective coding, the researcher then organized and integrated the categories and themes that provided an understanding or theory about the phenomenon (Charmaz, 2014).

Trustworthiness

Credibility within qualitative data analysis can be dependent on judgment (Patton, 2015). Qualitative research requires substantial evidence that builds within the design of the study (Rubin & Rubin, 2012). It was imperative that the researcher accurately reported, interpreted, and analyzed participants' responses. All observation, recording, and reporting was presumed correct. The researcher double-checked, cross-referenced, and researched throughout the analysis process. Rubin and Rubin (2012) encouraged researchers to report accurately and transparently what was heard and how the analysis was administered. The sample determined credibility. The researcher confirmed that all sample participants fit the criteria for the study. The participants were able to provide examples, descriptions, and feedback of stand practices and beliefs regarding the phenomena. A sample of Black churchgoers diagnosed with hypertension increased the credibility of the research.

Transferability provides the readers with evidence that findings can be applied to other situations and populations (Cottrell & McKenzie, 2005). The current study had external validity because it generalized the results to other groups and setting. This study provided the evidence that findings can be applied to other populations, chronic illnesses,

religion, and setting. Dependability in research is the stability of data over time and conditions (Rubin & Rubin, 2012). As new learning unfolded throughout the research process, the researcher documented and took account of the changes built into any setting, process, or research design. A code-recode procedure was conducted throughout the analysis phase. After the researcher coded a section of data, the researcher waited a few days and then returned and recoded the same data and evaluated the results. To guarantee dependability, the researcher used methodological experts from Walden's Center for Research Quality to examine the research plan and execution. Conformability is when research outcomes can be confirmed or corroborated by other researchers (Rubin & Rubin, 2012). The assure confirmability, the researcher documented the procedure of checking and rechecking the data for the duration of the research. After the study, the researcher inspected the data collection and analysis procedure to identify potential concerns for bias or distortion.

Ethical Procedures

Institutional Review Board (IRB) committees are useful and generative. They help the researcher conceptualize what potential harm might mean and look like in the proposed study (Ravitch & Carl, 2016). The term harm can be labeled in many different situations. For example, placing participants into focus groups or other positions that could expose individuals to discomfort or injury depending on the topic of relational/professional/community dynamics without considering the implications for them during or after the group or interaction could be considered harmful (Ravitch & Carl, 2016). The research participants have been selected for this study. Participants who

volunteered to partake in the face-to-face and teleconference interviews signed or e-signed an informed consent. The informed consent provided the participants' disclosure of relevant information, their comprehension of the information, and their voluntary agreement (Cottrell & McKenzie, 2005). The researcher protected the information provided by the research participants. The data that contained personally identifiable information were collected and stored on paper and electronic form. Electronic storage included a mobile device (audio recording), personal laptop, thumb drive, and online storage, which is privately owned. The computer and server used to store data was password protected. The researcher's laptop and portable devices were secured; because of the significant risk for identifiable data being misplaced or stolen. The identifiable data collected on the researcher's laptop and portable equipment were encrypted and moved to secured, non-portable equipment. The investigator was the only individual who had legitimate access to an identified data. This procedure ensured that a data set cannot be permanently lost and secure.

Ethics and trustworthiness are crucial in all research. Resnik (2015) defines ethics as norms for conduct that distinguish between acceptable and unacceptable behavior. Knowing what constitutes ethical research is essential for all people who conduct research projects or use and apply the results from research findings. This research revolved around the issues of religion and health. Religion and religious affiliation were considered sensitive personal information (Ravitch & Carl, 2016); if released, there was a possibility it could lead to social stigmatization or discrimination. The science of medicine may contradict with the idea of healing through faith. Health care professionals

may have contradictory or opposing views on how religion can be incorporated into a clinical setting. This idea may present an ethical concern for some providers, but the research showed how important religion is to health care. According to Casarez & Engebretson (2012), health care providers have an ethical obligation to attend to all dimensions of a person and provide holistic care.

Adhering to ethical norms in research is essential. Ethics in research promotes the aims of the study, such as knowledge, truth, and avoidance of error, which can prohibit against fabricating, falsifying, or misrepresenting research data to support the truth and minimize error (Resnik, 2015). To ensure credibility for this research, the researcher administered purposeful random sampling. This approach may negate charges of bias in participant selection and to ensure that any "unknown influences" are distributed evenly within the sample (Shenton, 2004). Shelton (2004) also stated that random sampling provided the highest assurance that those selected are a representation of the larger group. This research revolved around the issues of spirituality, religion, and health. The science of medicine may contradict with the idea of healing through faith. The researcher was ready to hear opposing or contradictory points and views from participants. To get authentic and genuine data, the researcher encouraged participants to be frank and to speak freely (Shelton, 2004). Researchers cannot allow personal views or biases to interrupt any of the processes.

Summary and Conclusion

Chapter three discussed the methodology that were used to investigate how religious practices influenced self-care in Black churchgoers diagnosed with

hypertension. This qualitative study used the grounded theory approach to identify themes and concepts that emerged, which helped identify the influence that religious practices have on hypertension self-management among Black churchgoers ages 18 and over. A minimum of twenty Black churchgoers, males, and females were recruited to participate in interviews. In addition to manual data analysis, software such as *NVivo 12 Plus* was used to assist thematically analyze the data and identify themes to answer the study research questions. Chapter 4 presented the results of the analysis.

Chapter 4: Results

Introduction

The prevalence of hypertension in Blacks in the United States is amongst the highest in the world (Virani et al., 2021). According to the American Heart Association's 2019 Statistical Fact Sheet, among Blacks age 20 and older, 58.6% of males and 56% of females had high blood pressure. This qualitative study aimed to explore how religious practices influenced the self-care of Black churchgoers diagnosed with hypertension. This approach allowed the researcher to examine the experiences and understanding of how Black churchgoers utilize and implement religious practices into their hypertension self-care. Additionally, this approach allowed the researcher to identify themes and concepts associated with their experience. This qualitative design used open-ended semi-structured interviews, and criterion sampling was used to elicit participants' responses regarding religious practices and its influence on self-care of their hypertension. During the data collection phase from this grounded theory study; the researcher identified two emerging themes with four sub-themes after collecting information from twenty-one study participants.

Research Questions

The following research questions were developed during the research's inception to help guide: How do religious practices influence self-care in Black churchgoers diagnosed with hypertension in the Southeastern United States?

From the question, two other questions were developed as sub-questions:

1. How do religious practices influence health promotion in Black churchgoers diagnosed with hypertension in Southeastern US?
2. What religious factors influence self-care in Black churchgoers diagnosed with hypertension in Southeastern US?

In chapter 4, the researcher discussed the techniques used for recruitment, data collection, analysis, and study results.

Setting

The setting for this study was in the Midlands and central part of the state of South Carolina (SC). According to the United States Census Bureau (2020), Blacks make up 27 % (1,390,152) of SC's population. Interviews were conducted with Black churchgoers, 29 years and older, with a reported clinical diagnosis of high blood pressure (hypertension). The study was approved by Walden University institutional review board and community organizations (local church) that served as recruitment sites. The researcher had 100% participation from the recruited churches. Both churches provided a letter of participation to the researcher. Each letter was signed by the senior pastors from each church.

Purposive sampling was used to select information from the best representatives of the population. Two predominantly Black member attended Baptist churches, both located in the central region of SC, were selected to assist with recruitment. Due to the COVID-19 pandemic, all face-to-face church services and programs had ceased. The organization leaders recruited participants using emails, e-newsletters, and church announcements (Appendix F) disseminated by the pastors to the congregation.

Recruitment efforts involved initially meeting with senior pastors, first ladies, and church leaders. The two pastors shared the recruitment flier (Appendix C) with their congregations. Interested participants contacted the researcher (via phone or email) to set up an appointment (virtual or face-to-face) to be interviewed. Volunteers were screened for eligibility. If criteria were met, interviews were set up during the specific date, time, delivery modality, and locations suitable for their schedule and comfort. Participants signed the informed consent or replied 'I consent' before each interview. Individuals were also recruited through snowball sampling. Data collection stopped after the desired sample size (20 participants) was acquired, saturation and informational redundancy were achieved. The time frame for data collection was approximately three months.

Demographics

Participants were black men and women churchgoers diagnosed with high blood pressure (hypertension). The inclusion criteria for this study were:

1. African American adult (ages 18 years and older)
2. Clinically diagnosed with high blood pressure (HTN)
3. Member or affiliated to a church or ministry.
4. Able to write and speak the English language.
5. Have not been diagnosed with a terminal illness, mental, or psychological diagnosis or disorder.

The sample of Black churchgoers with hypertension consisted of 8 males and 13 females (n=21). Their mean age was 55 years old, with an age range of 29 to 70 years. All had been clinically diagnosed with hypertension for a means of 15 years. The range for hypertension diagnosis was two weeks to 38 years. There was a range for participant's education level, including high school diploma (n=2); some college (n=8);

Bachelor's degree (n=4); Master's degree (n= 6); and postgraduate degree (n=1). Only 1 of the 21 participants worked part-time. Fifty seven percent (n=12) of the participants worked fulltime; 19% (n=4) were self-employed; and 14% (n=3) were retired. Religious denominations include Baptist (7); nondenominational (7); Apostolic/Pentecostal (3); African Methodist Episcopal -AME (2); Jehovah's Witness (1); Self-Identified (1). Table 1 lists the participant's demographics.

Table 2

Demographic Profiles (n=21)

Pseudonym	Gender	Age	Denomination	Years Dx	Employment	Education
Bob	M	62	Non-denominational	4	Self	Some college
Brian	M	29	Non-denominational	17	FT	Masters
Byron	M	46	Apostolic	2	Self	Some college
Barb	F	43	Baptist	2 wks.	FT	Masters
Bonnie	F	59	Non-denominational	2	Retired	Masters
Becky	F	58	Baptist	30	FT	Masters
Bree	F	43	Baptist	2	FT	Masters
Bliss	F	53	AME	10	FT	Bachelors
Bella	F	57	Baptist	15	FT	Some College
Bev	F	62	Baptist	20	FT	Some college
Billy	M	51	Pentecostal	38	FT	High School
Brandon	M	58	Baptist	15	PT	Masters
Blanka	F	70	Non-denominational	19	Retired	Bachelors
Blossom	F	49	Apostolic/Pentecostal	12	FT	Bachelors
Brittney	F	64	AME	26	Retired	Some college
Barney	M	51	Baptist	10	Self	Some College
Bambi	F	57	Non-denominational	29	FT	Some College

Breanna	F	49	Non-denominational	2	Self	Post Grad
Buck	M	47	Jehovah's Witness	1	FT	Some College
Beauty	F	53	Non-denominational	20	FT	Bachelors
Bernie	M	50	Self-Identified	32	FT	High School

Note. Years Dx = Years diagnosed; FT= Fulltime

Data Collection

Methods

Interviews with 21 Black men (n=8) and women (n=13) were administered using open-ended semi-structured interviews. An interview guide was used and approved by the researcher, research chair, and committee. The interview guide included questions to capture participant's demographic information, religious experiences, and hypertension management. The study was explained, and informed consent was obtained before each interview. The researcher began the semi-structured interview. All interviews were recorded by audio and/or video. Due to the COVID-19 pandemic, 71% of the interviews were administered using a video conference (n=15).

All video conference interviews' audio and video were recorded with consenting permission from the volunteers and saved. Two interviews were administered face-to-face, and four were conducted by telephone. The face-to-face and telephonic interviews were recorded by an audio recording device and archived. Demographic data questions were developed and collected by the researcher. Demographic data included gender, age, religious denomination, length of time diagnosed with hypertension, employment status, and educational level. For the open-ended interview, key questions were: *(a)* What role does religion play in your life? *(b)* Which religious practices are important to

you? *(c)* What are some of your beliefs regarding religion and health? *(d)* What things do you do to take care of your hypertension? *(e)* What religious practices make it easy for you to manage your hypertension? *(f)* How does your religion connect with the management of your hypertension? Responses were clarified and validated during the interview to confirm the researcher's accurate interpretation. To ensure in-depth responses, the researcher used probing. The questions were rephrased based on the participant's responses or comprehension of the question. The participants were interviewed once, and each interview lasted about 30-45 minutes.

Data Analysis

Data were analyzed after data collection was initiated. Interview videos and audio were transcribed and validated by the researcher. The researcher imported interview audio into the *Transcribe* app, in addition to hand transcribing verbatim.
The *Transcribe* app allowed the researcher to upload the audio file into the app automatically. There was not one hundred percent complete accuracies with the transcription, but the process was straightforward. Also, due to the inaccuracy of the transcription, the researcher cross-referenced and edited the transcripts manually. The cross-referencing allowed the researcher to discover misinterpretation and eliminated content. Manually transcribing the data into a spreadsheet helped with validity and reliability (Saldana, 2016). To validate accuracy, the researcher verified the transcripts with the audio and video recordings from each interview.

The data was then organized using Microsoft Excel. Pseudonyms were used to protect the confidentiality and privacy of study participants. Open, axial, and selective

coding was the guiding method used for analysis. These analysis methods orientate from grounded theory (Saldana, 2016). All the data was managed and coded by the researcher. NVivo 12 plus, a qualitative research data management software program, was used to assist with coding and identifying themes. The researcher used NVivo as a guide to initiate coding and themes in addition to manual data analysis. The researcher created a process board to validate and confirm themes.

As stated above, all audio and video recordings were transcribed verbatim. The researcher reviewed the transcript to develop the codes used to identify the themes within the data. The code and theme development were based on the correlation or connectivity between religion, religious beliefs, and hypertension management. The researcher had documented analytic notes, personal insight, and reflections and considered items during the analysis. Accounts for the individual participants were compared with each other to classify recurrent themes. Through recurrent reading and analysis, codes and categories were developed. This coding list was then applied to the entire data set. Further modifications were made until the list was validated.

Initially, the researcher identified three groups: (1) Religion enhanced/reinforced behavior for self-care with intentions of healing; (2) Religious teachings/instructions that influence behavior with intentions of healing; (3) Religious practices used for self-care with intentions of healing. All responses were selected and filtered into appropriate categories. During open and axial coding, two symbolic classifications emerged: (a) **religion** enhanced self-care behavior with intensions of healing; (b) **religious teachings** that impact behavior for self-care. Two profiles within each classification were

discovered. Two profiles within **religion** emerged: (a) *health awareness*; (b) *self-awareness*. With further reflection, the researcher discovered profiles that emerged within **religious teachings**: (a) *God's role*; (b) *Biblical instruction*.

Each profile was coded according to consistency and the researcher's interpretation of the participants' experience and relationship to religious practices, religious teachings, and religion. The profiles were compared for similarities and differences. In selective coding, the core construct, *Guide*, was integrated into a theoretical structure. Lastly, the participants identified three themes related to religious practices as a guide or strategy to assist with hypertension management. These themes identified: *prayer*, *Bible*, and *social support*. Table 2. below shows the definitions for each theme.

Table 3

Definitions for Themes

Themes for Religious Practices	Definition
Prayer	Included daily prayer, private prayer, talking to God, confessions, corporate prayer, and prayer/inspiration books.
Bible	Included daily Biblical reading, reading scriptures, reading educational biblical books, religious books, individual and corporate bible study.
Social Support	Included church services, corporate church fellowship, and preached messages (in-person/virtual)
Themes for Religious Teachings	
God's Role	Description of how God interacted during certain life situations.
Biblical Instruction	Biblical scriptures that encouraged certain behavior and actions. Also referred to *The Word of God, The Word, God's Word, Lord's Word, Bible, and The Word of the Lord*.
Themes for Religion	
Health-Awareness	Received health related knowledge and performed actions for preventing and managing high blood pressure. Received care-management awareness by seeking medical support, medication adherence, external health education and classes performed by healthcare professionals.
Self-Awareness	Acknowledged a conscious knowledge of feelings, motives, and desire (discipline, self-control, will power, confidence, hope, empathy, patience)

Evidence of Trustworthiness

Credibility within qualitative data analysis can be dependent on judgment (Patton, 2015). Qualitative research requires substantial evidence that builds within the design of the study (Rubin & Rubin, 2012). The researcher accurately reported, interpreted, and analyzed participants' responses. All observations, recordings, and reporting were done appropriately. The researcher double-checked, cross-referenced, and researched

throughout the analysis process. Rubin and Rubin (2012) encouraged researchers to report accurately and transparently what was heard and how the analysis was administered. The sample for this research increased the credibility of the data. The researcher made sure that all sample participants fit the criteria for the study. The participants were able to provide examples, descriptions, and feedback of practices and beliefs regarding the phenomena. The sample of Black churchgoers diagnosed with hypertension (n=21) increased the credibility of the research.

Transferability provided the readers with evidence that findings can be applied to other situations and populations (Cottrell & McKenzie, 2005). The current study had external validity because it generalized the results to other groups and setting. This study provided the evidence that findings can be applied to other populations, chronic illnesses, religion and setting. Dependability in research is the stability of data over time and conditions (Rubin & Rubin, 2012). As new learning unfolded throughout the research process, the researcher documented and considered of the changes built into the setting, process, or research design. A code-recode procedure was conducted throughout the analysis phase. After the researcher coded a section of data, the researcher waited a few days and then returned and recoded the same data and evaluated the results. To guarantee dependability, the researcher used methodological experts from Walden's Center for Research Quality to examine the research plan and execution. Conformability is when research outcomes can be confirmed or corroborated by other researchers (Rubin & Rubin, 2012). The assure confirmability, the researcher documented the procedure of checking and rechecking the data for the duration of the research. After the study, the

researcher inspected the data collection and analysis procedure to identify potential concerns for bias or distortion.

Results

In this study, participants described two symbolic classifications about religious practices and hypertension self-care (see Table 3). Self-Care Guided Through Religious Practices was identified as the foundation or core construct in this study. The findings showed that prayer, Bible and social support guided the self-care of hypertension through religious teachings and religion. The classification was shaped by the participant's use of religious practices as a guide to assist with self-care. Two symbolic classifications were identified. These classifications are Self-Care Guided Through Religious Teachings: God's Role & Biblical Instruction; and Self-Care Guided Through Religion: Health-Awareness & Self-Awareness.

Self-Care Guided Through Religious Teachings: God's Role & Biblical Instruction

Based on the data analysis for this group, religious teachings guided self-care. Religious teachings were principles, doctrine, and guidelines that were precepts from participants' religion. These religious teachings were received through biblical instructions and the role of God. It also influenced behavior with intentions of healing. Biblical instructions provided information that encouraged participants' behavior, actions, and intentions. Many of the participants referenced the Bible to receive guidance regarding healing and health. The Bible identified who God was and the role He played. The Bible was also referenced as *The Word of God, The Word, God's Word, Lord's Word*, and *The Word of the Lord*. These references were all used interchangeably to refer to the

Bible. The practices associated with religious teachings were prayer, Bible, and social support (see Table 3).

God's Role

Thirteen of the 21 participants mentioned God and the role He played in his or her everyday life. Participants' religious teachings anchored them to understand that God is with him or her. Also, God resided in him or her and sustained the hope for healing and support for better health outcomes. These findings aligned with literature that focused on diabetes self-management through a relationship with God (Polzer & Miles, 2007). God's role had an interconnectedness to hope and confidence in the data analysis. The participants' religious teachings were identified through prayer and biblical instructions. God was classified as a healer, creator, and comforter. Also, participants emphasized that God gave them wisdom, advice, and guidance through prayer. Prayer to God was the most common form of communication. Participants used scriptures as an instructional tool to understand and learn how to pray to God for their needs or as conversation. Through religious teachings from the Bible, participants identified God created and sustained man. Below are nine descriptions from participants:

> "He is a comforter through these times here on Earth. He is a comforter. It takes the help of the lord to battle bad habits that I had with eating or just not moving." – Bella, 57, female
>
> "God, my-the creator is the giver and sustainer of life and through that life He has given us everything we need including healing." – Bonnie, 59, female

"He knows what is best for me. If I did not have God or the outlet of God to relieve certain stresses in my life the outcome would be different." - Bambi, 57, female

"God is love." – Bernie, 50, male

"But we know according to *Titus* 1:2 that God can not lie, so we know that it is going to happen. If he said he is going to put an end to it- we believe that." – Buck, 47, male

"I do think God is a healer, I think by staying connected to God and the Holy Spirit." – Breanna, 49, female

"It plays a 100% role in my life, because I don't doubt God in anything. I have to get back to my spiritual side and realize that God is still able. I am a child of God and He said that nothing is too hard for Him." – Billy, 51, male

"God made man, that mean whatever man can do to prolong your life, I think that is part of God's will. I can depend on God. God keeps me going." – Bev, 62, female

"No matter how you look at it – Our Lord and savior Jesus Christ, He is God." – Brittney, 64, female

Participant's belief of God being a healer, through scripture and experiences, provided evidence of healing and control over one's life expectancy. The Biblical scriptures provided evidence of God's ability to provide deliverance from pain and suffering. God was described as a keeper and comforter, supported by Biblical passages,

as a source of strength. Bible passages were reminders of God's previous acts of grace, goodness and mercy with others, and participants from this study believed that God would do for them what He did for others in the Bible. Participants also used Biblical passages to communicate with God by submitting a request for strength, knowledge, and relief. The majority of participants asked God for strength and knowledge on how to manage their hypertension. In conclusion, faith in God sustained each participant's hope for healing. God's role also supported their expectations for better health outcomes. The self-care of hypertension and the stress of everyday life can be overwhelming but having that support and guidance from God provided confidence and hope. Healthcare professionals can use this data to help guide patients with hypertension self-care. In addition, this data can be used to help train healthcare professionals regarding patient's motivations and decision making.

Biblical Instruction

Previous studies on religion and health, reported the importance of reading the Bible for individuals coping with chronic illnesses (Namageyo-Funa, Muilenburg & Wilson, 2013; Choi & Hastings, 2019). The Bible provided the participants with the instructions that encouraged specific principles and guidelines that influenced behavior with the intention of healing. The Bible guided participants on longevity, healing, and caring for the body through prayer, biblical instruction, and social support (Table 3). According to this study, 20 of the 21 participants believed that everything written (scriptures) in the Bible is truth. Six participants reported the following about the Bible's truths and teachings.

"We do believe in the different things that are taught in the Bible, as far as what the Word of God says, we believe it was inspired by man." – Blossom, 49, female

"I believe that whatever the word says- I can have because the Father doesn't lie. Whatever the Word says, that is what I believe." – Blanka, 70, female

"I try to follow the Word. I try to embed the teachings of the ten commandments. The Bible is the Koran, it's just a different version of it. It is the teachings of my family, growing up as a youth. Trust the Word of the Father and the teachings of the Bible and be true to yourself." – Barney, 51, male

"The *Book of Proverbs* is a wisdom book. And in chapter 4 it reminds me of how important the Word is because in Chapter 4 and verse 22, the Word of the Lord says, '*pay attention to the Word'*. It has pay attention to the Word and not to only be hearers only. But the Word of God is life. So, I believe that the Word is health to my flesh, and I have a responsibility to speak the word of God into my flesh, and I do believe that I am flesh, I am spirit, I am a soul." – Bambi, 57, female

"We believe in the Old Testament, Genesis through Revelation." – Billy, 51, male

> "I try to live my life based on the Bible as being my road map. It helps me in life and everyday decisions and just try to live according to God's Holy Word." -Becky, 58, female

This finding is consistent with what historians and theologians have suggested about a Black theology that evolved during slavery. The African slaves learned to relate stories and passages from the Bible of other oppressed groups to their own suffering (Hamilton et al., 2016). Additionally, some of the participants reported the Bible's guidance and instruction on healing. Five participants provided their beliefs regarding the Bible's instructions on healing:

> "In reading the Bible, the words from the Bible, they say, '*by His stripes we are healed'*." - Bree, 43, female

> "One of the religious practices is following the Word, obeying the Word that you read. One of the things is a scripture that talks about '*I place before your life and death and the choice to choose life'*. So, I think the religious practice I use is doing and choosing life and I think I choose life when I obey God's Word. It plays a role in that I depend on the teachings every day to help inspire and motive healing and whatever I need for a particular day." – Bonnie, 59, female

> "Jesus says, '*by His stripes I am already healed'*. When he died on the cross, He took care of all of that-my healing, my everything that pertains to life. And that pertains to righteousness." – Blanka, 70, female

> "I do believe in the Word of God, where it says, '*by His stripes I am healed'*. And I do believe, and I don't claim sickness." – Breanna, 49, female
>
> "I stand on a lot of scripture. *Isaiah* 53:5, that says '*that God was wounded for my transgressions and He was bruised because of His death, burial, and resurrection'*. I believe my healing is already complete. Also, believe just the scripture alone, that lets me know that Psalms 107:20, that says '*He send His word, and He healed me and delivered me of all my discretion.*'" – Blossom, 49, female

These scriptures explained the ability that God has to heal and to promote longevity. Participants mentioned scriptures from the Old Testament that included passages from the Book of *Titus*, *Proverbs,* and *Isaiah*. Lastly, participants explained the guidance the Bible provided regarding taking care of their bodies. Participants referenced the body, as illustrated in the Bible, as the *temple* and how important it is to take care of it. Bob, 62, mentioned The Old Testament Book of *Leviticus* as a teaching tool that provides guidance on foods people should and should not eat. Bella, 57, mentioned the Bible provides dietary examples like the Daniel diet to eat correctly. Nine participants provided examples of the Bible's instructions on eating and caring for the body:

> "But my main focus is what the Lord says in His Word concerning my health." – Bambi, 57, female
>
> "Because we have been given examples in the Bible, the Daniel diet, eating fruits and vegetables, I connect with that as far as putting good

things into this old body. To do anything in access is a sin. A sin against God because we are not taking care of it. I'm sure there is scriptures that talks about taking care of this vessel that we have on earth." – Bella, 57, female

"Religion teaches us that a man or a person is not supposed to be. The Bible used the term gluttonous; we are not supposed to overeat or when you go into the Book of *Leviticus* it teaches us about different foods that we should not eat. The Bible tells us these things, to let us know of how we are supposed to take care of our body. How we are supposed to do our best to take care of our body. How we are supposed to do our best to be healthy in our body as well as strive to be healthy in our spirit." – Bob, 62, male

"We encourage that God wants His servants to be clean. Because we are always cautious about keeping your homes clean, your vehicles but most important your body. We want to represent the Most High, and in His scriptures, He tells us '*to be clean*.'" – Buck, 47, male

"Discipline. Well in the Bible it teaches you how to push away from temptation. Certain foods we shouldn't eat because it has been proven to be unhealthy for you. Certain that might not taste as good, it is healthy for you." - Barney, 51, male

"It's all about the Bible. The Bible says, '*that if the soul prospers also your body'*. So, there is a connection. You know it is not separate, but it is

> together. Like I said earlier we were first spiritual before natural, so it connects to the spiritual because if we want to have a long life, we have to take care of our bodies, take care of our minds." – Byron, 46, male
>
> "I think when we think about scripture, like our bodies are out temples and also like our bodies in my opinion are being our own." – Brian, 29, male
>
> "Religion teaches you that your body is the temple of God, and God wants us to take care of these temples in the present because that is what we have here and now." – Brandon, 58, male
>
> "Even though I can't go to church, I always say that I am the building, and I am the temple and to keep my temple strong I need to do what I am supposed to do. I am the church. I am the temple. So, I need to keep it strong, I need to keep it right, I need to keep it where it is supposed to be a good dwelling place." – Bliss, 53, female

These scriptures and themes support the emphasis of biblical teachings on health, God's nature, and the role He plays. This finding aligned with the literature that suggested individuals used the Bible and understood God's role to help cope with life stressors and manage type 2 diabetes (Namageyo-Funa, Muilenburg & Wilson, 2013). This finding was also similar to data reported in studies regarding individuals' connection with God to seek guidance and help to understand their situation (Casarez, Engebretson & Ostwald, 2010; Polzer & Miles, 2007). Given the value of reading the Bible for churchgoers with hypertension, healthcare professionals could incorporate the use of Biblical content to help with self-care.

Table 4

Summary of Themes

Religious Practices	Religious Teachings	Religion
Prayer	**God's Role** • God is a comforter. • God is a keeper. • God is a healer. • God gave wisdom. • God gave advice. • God gave guidance. **Biblical Instruction** • Instructed to have a relationship with God. • Defined God's role. • Provided guidance on how to communicate with God.	**Health-Awareness** • Received advice from God on decision making for HBP management. • Reminder to do HBP self-care. **Self-Awareness** • Enhanced self-confidence for HBP self-care • Received a mentality to trust God to help with HBP healing. • Believed to be off medication.
Bible	**God's Role** • God is the creator of man and has the power to heal. • God is in control. • God gives and sustain life. **Biblical Instruction** • Provided instructions on healing and taking care of the body. • Provided instructions on eating certain foods. • Provided instruction that encourage specific guidelines for longevity. • Provided instructions to be clean and honorable to Christ.	**Health-Awareness** • Provided instructions on how to take care of the temple (body). • Provide encouragement to follow a particular diet. • Provided encouragement to focus on Jesus, who is the healer. **Self-Awareness** • Scriptures provided self-motivation, reassurance, and confidence that God can heal. • Encouraged prosperous life. • Helped to inspire and motive healing.
Social Support	**God's Role** • NA **Biblical Instruction** • Bible speaks on the importance of fellowship to help one another.	**Health-Awareness** • Received advice on HBP self-care. • Accountability is encouraged for HBP self-care. • Received support for self-care of HBP. • Preached messages about how God wanted them to take care of themselves to be healed. • Opportunity for education, healthy eating, exercise

	• Opportunity to learn about what God said about health and self-care. **Self-Awareness** • Gained inner strength. • Gained motivation. • Gained confidence. • Strengthened personal improvement/enhancement. • Increased faith that God can heal.

Note. HBP= high blood pressure.

Self-Care Guided Through Religion: Health-Awareness & Self-Awareness

Also, religion guided self-care. Webster (2021) defines religion as "a set of beliefs concerning the cause, nature, and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs." Religion stimulated a sense of awareness. For study participants, religion enhanced inner qualities. Religion enhanced or reinforced behavior for self-care with the intention of healing. Two profiles emerged during data analysis regarding religion. There was an interconnectedness of health-awareness and self-awareness with religion (see Table 3). The foundation of religion guided behavior and created a sense of awareness. Awareness is defined as "knowledge or perception of a situation or fact" (Webster, 2021). All the participants exemplified an awareness of health.

Health-awareness for the study participants included healthier food choices, staying active, less stress, and getting rest. Health-awareness encompassed self-care management, including medication adherence, attending classes, receiving care and advice from healthcare professionals. Additionally, self-awareness was a profile that

emerged from religion. The participant's conscious knowledge of his or her feelings, desires, and motives was highlighted. Participants' self-awareness feelings and characters included discipline, self-control, self-love, will power, confidence, hope, empathy, and patience. The practices associated with religion were prayer, Bible, and social support (see Table 3).

Health-Awareness

All participants (n=21) understood health-related knowledge needed to prevent and manage hypertension. One hundred percent of the participants took health-related actions to help manage his or her hypertension. As stated earlier, health-awareness included actions that supported having the knowledge to prevent and manage their hypertension. Activities included staying active, managing stress, getting rest, and choosing healthier food. Health-awareness was identified through the practices of prayer, Bible, and social support. Below are statements from nine participants that align with health-awareness.

> "Every so often I learn something new about hypertension. I am learning what to do. I am purposely, planning and am coming off blood pressure medicine. My diet, I am on a different type of diet now." – Blanka, 70, female
>
> "I believe that doctors are important, medical field are important, I do listen to their opinion on different things." – Bambi, 57, female
>
> "My blood pressure comes more from stress than anything, and my doctor tell me that." – Beauty,53, female

"You know the Bible says for as your souls prosperous so shall your body. So, in other words first we are spiritual first, our bodies are supposed to be healthy and line up with our mind because there is a word called being psychosomatically in sync, it encompasses the spiritual, naturally, emotionally, the social, and financial." – Byron, 46, male

"I go to classes and try to be mindful of what I am putting into this body that will hurt or raise my blood pressure." – Bella, 57, female

"I know a lot of it has to do with what I eat what I put in my body and the stress on my body. I know that they are some key factors of managing hypertension as well as rest." – Becky, 58, female

"I learn that just resting, eating well, keeping my body well that takes care of a good portion of it." – Barney, 51, male

"Say I have an ache- even though I pray about it, I still go to the doctor to get it checked. Because I still think you need to use wisdom. Medical professionals are here for a reason. So, like with my blood pressure, even though the doctors have diagnosed me with high blood pressure, I know if I change my habits that it can go away. I do believe that-I can pray about it all day but if I don't do some actions and exercise and eat healthier, I am going to keep it. It ain't going to go nowhere." – Breanna, 49, female

"In church my pastor constantly talks about the importance of taking care of yourself and doing those things if you have hypertension. Do those

> things to get rid of that. He is highly into that to help us, to guide us in the right way but it is up to us to do the right thing." – Bree, 43, female

In conclusion, religion guided self-care through religious practices with health-awareness. One hundred percent of the participants took health-related actions or received guidance that helped manage their hypertension. Through prayer, participants received advice on hypertension management advice and were reminded to do hypertension self-care. The Bible provided participants with instructions on how to take care of the body and diet. With social support, which includes church services, participants received advice on hypertension self-care, received accountability and support, heard messages about health education and how God wanted them to care for themselves.

Self-Awareness

All participants (n=21) had a conscious knowledge of their feelings and motives that enhanced self-care behavior with healing intentions. As stated earlier, self-awareness is one's knowledge of feelings, motives, and desires (Webster, 2021). Some enhanced inner qualities identified from this group were self-control, love, willpower, hope, and confidence. Self-awareness was identified through the practices of prayer, the Bible, and social support. Below are statements from nine participants that shared how their religion enhanced self-awareness.

> "The two main beliefs is loving one another and loving yourself. I guess I need to turn it around in loving yourself. If you can love yourself, you can love someone else and loving yourself you do what you need to do to

make yourself better every day. If it's through that health, spiritual, emotional, whatever love yourself first. Definitely prayer and encouraging yourself sometimes you got to encourage yourself and say hey I can do this." – Bliss, 53, female

"You have to have the will power to do it and trust me there has been times when Lord knows- there are times that I'm tempted and I'm like 'devil get thee behind me' because it ain't happening." – Brittney, 64, female

"I have to live by example, I am a minister, I am an elder, and I have to live by example." – Billy, 51, male

"I believe that most of my decision making or just how to lead my family is based on my faith." – Brian, 29, male

"I feel good about it, knowing that I am getting ahead of it, and I will soon be off- that is my goal. I am excited about it that one day the blood pressure medicine, my goal-period, is to be off the medication- period." – Blanka, 70, female

"Anyway, you know I get off track in maybe my eating or may whatever it might be. I have got this anchor that keeps pulling me back that's centering me, so I think that's the greatest benefit of my faith." – Bonnie, 59, female

"It (religion) is day to day, how I interact with people, my own personal enhancement." – Barney, 51, male

"The role religion plays in my life is structure, religion gives me structure. Religion gives me a hope, number one but religion helps me to have a moral compass. Religion helps me be able to think about things other than myself, it helps me to consider others. Religion helps me to look beyond myself and religion helps me to be able to be more concerned about others. My religion gives me a purpose again it gives me focus and as long if stay in purpose and I stay focus, hypertension has no place in my life. When I am calm when I'm in purpose. As long as I stay in purpose my hypertension cause I'm thinking no, I'm conscious. I conscious of things down to my eating." - Bob, 62, male

"Religion is the foundation of who we are." – Byron, 46, male

"Well with your health first and foremost you got to learn to take care of number one – yourself. You got to love yourself and you go to want to take care of yourself. So, I always say first take care of you, take care of number one first because you got to be around to take care of someone else." – Brittney, 64, female

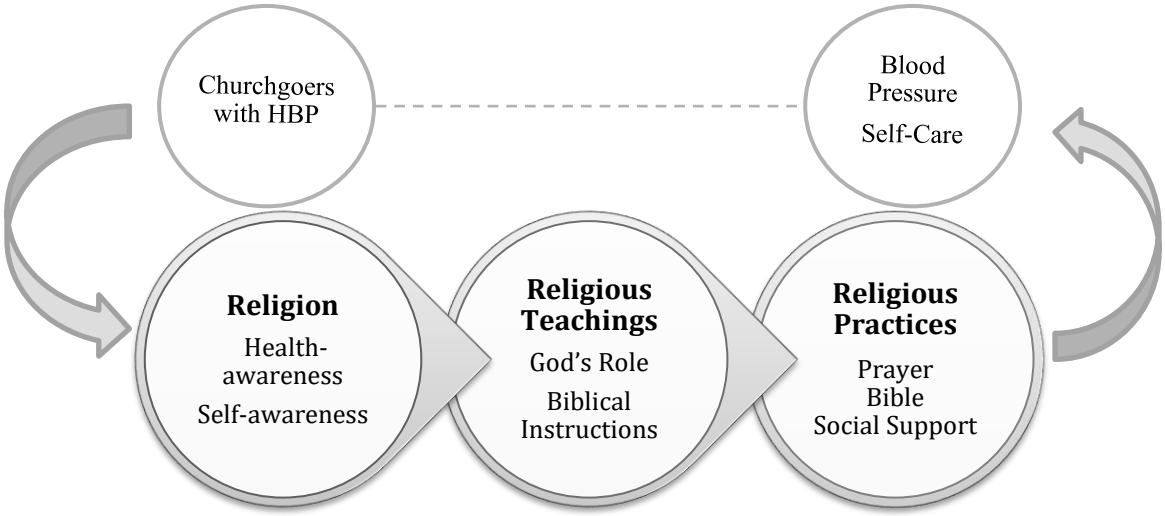
"Religion is very important role, because majority of the time it guides my decisions about life and health." – Brandon, 58, male

In conclusion, religion guided self-care through religious practices with self-awareness. Self-awareness stimulated an awareness of patience, willpower, motivation, and inspiration. Through prayer, confidence for hypertension self-care enhanced; received a mentality to trust God to help with hypertension healing; and believed to be

off medication. The Biblical scriptures provided self-motivation and confidence that God can heal, encourage prosperous life, and inspire and motivate healing. Through social support, participants gained inner strength, motivation, and increased faith that God can heal.

Figure 1

Religion's Influence on Self-Care



Summary

The study's purpose was to explore how religious practices influenced the self-care of Black churchgoers diagnosed with hypertension. Data were collected by semi-structured recorded (audio or visual) interviews from twenty-one Black churchgoers diagnosed with hypertension. The researcher identified two main themes and four sub-themes that emerged. *Religion* was identified as the central theme, with *health-awareness* and *self-awareness* as supportive themes. Additionally, *religious*

teachings was identified as the central theme, supported by *God's Role* and *Biblical Instructions* as sub-themes. These themes identified helped to interpret the main research question (a) How do religious practices influence self-care in Black churchgoers diagnosed with hypertension in Southeastern US? Identified themes also helped answer the additional research questions (a) How do religious practices influence health promotion in Black churchgoers diagnosed with hypertension in Southeastern US? (b) What religious factors influence self-care in Black churchgoers diagnosed with hypertension in Southeastern US?

Religion stimulated a sense of awareness that was demonstrated through religious practices. The findings of this study confirmed that religious practices guided self-care in Black churchgoers diagnosed with hypertension (Figure 1). The data confirmed that prayer, the Bible, social support originated from religion, and religious teachings influenced this population's self-care. Religion stimulated a sense of awareness that enhanced behavior for self-care with the intention of healing. Religious teachings, instructions cultivated from religion impacted the behavior to act. *Religious practices* are traditions and methods used to carry out actions. All participants reported a positive experience with the use of religious practices on how an individual perceived their health and the management of their hypertension. Furthermore, as exhibited in the themes, the participants in this study used a religious practice daily to support self-care and endure life situations.

Chapter 4 provided a detailed description of the study participant recruitment, data collection process, data analysis, and results. In Chapter 5, the researcher reviewed

the interpretation, limitations, conclusion, and recommendations from the findings documented in Chapter 4. Implications for positive social change are also discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of the grounded theory study was to explore how religious practices influenced the self-care of Black churchgoers diagnosed with hypertension. The participants were Black churchgoers over the age of 18 who were clinically diagnosed with hypertension. In this grounded theory approach developed by Glaser and Strauss (1967), the researcher utilized the standard approach of comparative analysis to explain the phenomenon. A purposive sampling method was used for the recruitment of 21 Black participants who met the criteria. The findings presented are recommendations for future research and implications for social change. In the United States, there is a gap between the effects and complications of hypertension in Black adults and White adults. The research presented in the literature review identified:

1. Hypertension prevalence contributes to disparities in Black Americans (Howard et al., 2018).
2. There is a connection between religion, religious attendance, spirituality, and health outcomes (Bruce et al., 2017; Bowe et al., 2017; Dill, 2017; Millet et al., 2018).
3. Black Americans are considered to be the most religious racial/ethnic group in the US (Millet et al., 2018).

The findings of this study confirmed that religious practices guided self-care in Black churchgoers diagnosed with hypertension. Participants shared a wide range of religious practices that helped them cope with their hypertension self-care. The top three religious

practices that were identified were prayer, referencing the Bible, and social support. Each participant discussed how religion influenced every component of their day-to-day lives. These religious practices (prayer, Bible, and social support) were all regular performances taught from each person's religion. All participants viewed their specific religion or spiritual relationship as a positive contribution to a better quality of life. There was not any negative feedback regarding religion or any spiritual relationship. The data confirmed that prayer, the Bible, and social support originated from religion and religious teachings that influenced this population's self-care.

Interpretation of the findings

Black churches are essential for the African American community because they are seen as an asset and trusted resource, dating back to slavery (Cosby, 2020, Maxwell et al., 2019). Historically, it has been instrumental in the advocacy efforts for political, racial, and social injustice. Black churches also provided social services for underserved communities (Hankerson, Svob & Jones, 2018). In addition, the Black church plays a role in public health. It has been the focal point of community partnerships and academic research integration to create culturally relevant health interventions (Brewer & Williams, 2018). Previous data and the current study suggest that the Black Church is an excellent doorway for reaching African Americans to implement interventions (Hankerson, Svob & Jones, 2018; Brewer & Williams, 2018). This study provided a needed understanding of religion's influence on self-care. The study's results provided an understanding to help healthcare professionals engage in health promotion, health education, and intervention in Black Churches. Many religious leaders and organizations

address the physical, mental health, and social needs of their members. Black Churches have created 'health ministries' to help sustain and implement health programs (Maxwell et al., 2019). Church-based and faith-based health promotion is feasible and effective.

In this study, participants described two symbolic classifications about religious practices and hypertension self-care (Table 3). *Self-Care Guided Through Religious Practices* was identified as the foundation or core construct in this study. The findings showed that prayer, Bible and social support guided the self-care of hypertension through religious teachings and religion. The classification was shaped by the participant's use of religious practices as a guide to assist with self-care. Two symbolic classifications were identified. These classifications are Self-Care Guided Through Religious Teachings: God's Role & Biblical Instruction; and Self-Care Guided Through Religion: Health-Awareness & Self-Awareness.

Self-Care Guided Through Religious Teachings: God's Role & Biblical Instruction

Reading passages from the Bible, prayer and encouraging religious social support was a self-care method that promoted positive behavior for those Black churchgoers with hypertension. Biblical instructions provided information that encouraged participants' behavior, actions, and intentions. Many of the participants referenced the Bible to receive guidance regarding health, life decision, and self-management. According to many of the study participants, scriptures provided confirmation of healing by God. God's role as a healer, confirmed through the Bible, has the power and dominion over mortality and healing. Breanna, 49, stated that she believed God to be a healer. Bonnie, 57, identified God as the creator, giver, and sustainer of life. These findings are similar

to data reported in a study that identified God as a protector, beneficent and healer in African Americans who used the Bible for guidance, comfort and strength during stressful life events (Hamilton, Moore, Johnson & Koenig, 2013). Study participants also described God as honest, a helper, good listener, provider, and caretaker. The participants were turning to the Bible for textual support. The words from the Bible provided a sense of upliftment, encouragement and comfort knowing that God is in control. These scriptures and themes support the emphasis of biblical teachings on health, God's nature, and the role He plays. These findings align with the literature that suggested individuals used the Bible and understood God's role to help cope with life stressors and manage type 2 diabetes (Namageyo-Funa, Muilenburg & Wilson, 2013). Additionally, these findings were similar to data reported in studies regarding individual's connection with God to seek guidance and help to understand their situation (Casarez, Engebretson & Ostwald, 2010; Polzer & Miles, 2007).

Self-Care Guided Through Religion: Health-Awareness & Self-Awareness

Reading passages from the Bible, prayer, and encouraging religious social support was a self-care method that promoted positive behavior for those Black churchgoers with hypertension. Participants explained the Biblical guidance received that pertained to self and health awareness. According to Bambi, 57, her religion influenced her decisions. She stated, "It (religion) is pretty much a main role, because of it, I adjust my world around it. Whatever decisions I make, I consider that first before making decisions". The Bible provided instructions on healing and taking care of oneself. Instructions guided eating particular foods/diets, caring for the body (temple), and being clean and honorable to

Christ. One key variable of the theory of planned behavior includes behavior intention. *Behavior intention* is defined as the perception of behavior possibility (Glanz, Rimer & Viswanath, 2015). The measuring approach with religious influences is, "What does your religion say regarding performing the behavior"? According to study participants, the Bible provides instructions, rules, teachings, and lessons regarding caring for one's body. As illustrated in the Bible, participants referenced the body as the temple and how important it is to take care of it. Bob, 62, mentioned The Old Testament Book of *Leviticus* as a teaching tool that provides guidance on foods people should and should not eat. Bella, 57, cited that the Bible provides dietary examples like the Daniel diet to eat correctly. Bella, along with two other participants, also mentioned that it is a sin against God if people are not taking care of the temple. According to participants, the Bible provided clear instructions and guidance on how to manage one's health.

Perception on control behavior is an additional concept for the theory of planned behavior. According to Glanz, Rimer, and Viswanath (2015), *control behavior perception* is defined as confidence that one has to use control in performing a behavior. For this study, does religion determines how easy it is to care for hypertension? The data supports the concept of perception of controlled behavior. Religion, exemplified through prayer, the Bible, and social support, provided comfort, guidance, and support with these participants' self-care. Religion stimulated a sense of awareness that enhanced behavior for self-care with the intention of healing. Blanka, 70, supported by stating that she "believed whatever the Word says because the *Father* doesn't lie." Having this form of belief can lead to confidence and a sense of self-awareness to make healthier

choices. Bella's statement, "It (religion) keeps me together. We know we have to have hope and even in troubled times", confirmed that religion established a sense of awareness and confidence. For many of the participants, religion provided a sense of structure. Bob,62, stated that his religion provided structure, a moral compass, and a sense of hope. Religion created a sense of self-awareness, which created a conscious knowledge of one's motives and desires. Religion appears to function as a trigger for self-motivation and is used for copying. Furthermore, as exhibited in the themes, the participants in this study used a daily religious practice to support self-care and endure life situations.

The purpose of this study was to explore how religious practices influenced self-care in Black churchgoers diagnosed with hypertension. The data confirmed that religion had a positive contribution to self-care. The effectiveness of self-care execution and application from religion and religious practices overtime was not validated. Religion and religious practices were narrated as a supportive mechanism but not utilized for hypertension self-care execution. Religion guided behaviors, but the execution could not be determined. Religion varies based on theology. Future researchers should conduct new research that explores the effectiveness of a religious-centered hypertension education program in Black churchgoers.

Limitations of the study

This research does provide data that validates the role religious practices play in the self-care of Black churchgoers with hypertension. However, it is not without its limitations. The focus of this research was to understand how religious practices

influenced self-care in Black churchgoers. Although this data is vital to religion and hypertension in Blacks, the limitations listed should still be investigated—first, geographical location and inclusion criteria presented as a limitation. The small sample size does not represent all Black churchgoers in South Carolina or the United States. Recruitment was from a specific geographical area in South Carolina. This resulted in the generalization of other Black churchgoers diagnosed with hypertension. This research's findings did not apply to the entire population of Black churchgoers in Southeastern US or the US. Due to the study's limitations, researchers should conduct additional studies to build on this study exploring the differences between Blacks who identify and those who do not identify with a specific religion. Additionally, this research cannot be generalized to other racial and ethnic minority groups. Other racial and ethnic minority groups may carry different cultures and belief systems.

The theology of religion may be different in other cultures, races, ethnicities, and geographical regions. These findings collected data from 21 men and women identified as being affiliated with a Black church or ministry and diagnosed with hypertension. Religious affiliation was a criterion, which limited the sample size to Christian. The limited sample size included only Christian and only certain religions affiliated with Christianity. Although Christianity was the main religion present, another limitation present was the inclusion of various denominations. Different denominations convene differently, as well as apply different teachings and practices. This study did not include non-Christian religious groups, such as Muslim or Islam. There could be diversity in the

role religion plays in various religions and religious groups. Future research may also consider recruiting from other religions and denominations.

Religion and personal health could be a sensitive topic for some, which could have been a limitation concerning openness and authenticity. The researcher anticipated openness and honesty from all participants during the interview process, but there is no evidence to confirm that all participants were authentic with questions responses. The sensitive nature of the topic was acknowledged and informed to the participants before each interview. All participants were encouraged to share honestly to their best ability, and they did not have to answer any questions they did not feel comfortable answering. However, there is no clear evidence to prove that participants responded to interview questions to appease the researcher. Before recruitment, the researcher interacted with 10 of the participants. These interactions range from family members, an acquaintance of a family member, and the acquaintance of the researcher. Two study participants were the researcher's family members. Personal relationships and prior interactions outside of the study could have limited the participant's response. Due to the COVID-19 pandemic, a large percentage of interviews were administered via telephonic or virtual conference. The pandemic created an additional unforeseen limitation of internet access. Virtual conferences require internet access; for participants without internet, this was not an option.

Lastly, the average age for this sample was55 years old, and therefore, the findings may not be generalizable to older and younger ages. Younger adults, especially those aged 18-28 years, might conceptualize religion in different ways. In addition, each

generation has its unique life experiences and views on society. However, the results align with previous research that spirituality and religion influence the self-care of chronic diseases in Blacks (Namageyo-Funa, Muilenburg & Wilson, 2013; Hamilton, Moore, Johnson & Koenig, 2013; Casarez, Engebretson & Ostwald, 2010; Polzer & Miles, 2007). Thus, this study provides preliminary information that can be the foundation to the development of future studies that explores the use of religion among Blacks with hypertension.

Recommendations

This study provided a unique insight from Black churchgoers with hypertension and how religious practices influenced their self-care. The researcher found that religion provided a foundation and roadmap for all of the participants. The religious teaching provided tools, resources, and guidance to help them navigate from day to day. Prayer, the Bible, and religious social support were religious tools used that provided comfort and instruction. The Bible provided the instructions and was a resource used to help make decisions, while prayer was considered a conversation with God, which provided comfort and empowerment. Religious social support provided education, support, and accountability. Complementary and alternative medicine organizations and professionals have recognized the importance of addressing a culturally diverse patient population (Hodge & Wolosin, 2012).

The content presented in this study can be used to assist health educators, public health professionals, and healthcare providers in using passages from the *Bible* and prayer. Reading passages from the Bible, prayer, and religious social support was a self-

care method that promoted self-care for those Black churchgoers with hypertension. Future researchers could provide a comparison of which religious practices are more effective with self-care in this population. Researchers could identify which, if any, religious practices are more effective when it pertains to the self-care of this population.

Healthcare professionals can create initial care assessments to retrieve religious affiliation and identify a level of religious importance (Likert score). The information collected can assist professionals in delivering care. In addition, healthcare professionals can suggest Biblical passages, prayer, and religious social support as a form of self-care to assist with a patient's hypertension. Additionally, healthcare professionals can provide words, scriptures, and passages from the Bible as a self-care strategy when dealing with a hypertensive Black patient who feels anxious or stressed. Navigating hypertension self-management can be stressful for some patients. Considering that healthcare professionals are the first person present during diagnosis and care, encouraging patients to read a favorite scripture or payer, in addition to clinical care, can be a way to address a patient's spiritual needs.

Further research is needed to explore if these religious practices are strategies for self-care in Blacks who do not affiliate with a religion or church. By examining and comparing religious non-affiliation and affiliation groups, it could provide data to see how much religion has an influence on self-care in Blacks with hypertension. According to this study's findings, *religious practices* are a self-care method used in Black churchgoers diagnosed with hypertension. Future research could eliminate the assumption regarding religious practice used as a self-care method for all Blacks.

Additionally, other research can explore the correlation between religious practices and other chronic diseases among this population. Considering the disparities in CVD morbidity and mortality in Blacks, future research could examine other chronic illnesses such as heart disease and cholesterol. Although further research is warranted, this data suggested religious practices can be identified as a form of self-care amongst Black churchgoers. The data displayed in this research, considerably, is a 'best practice' when providing education, intervention, and care to Blacks. Studying the extreme disparities in CVD morbidity and mortality in Blacks compared to whites, it is essential to identify a practical way for healthcare professionals to approach self-care and religious, spiritual needs of culturally diverse patient populations.

Implications

This research addressed social change by providing data that can transform and alter the current culture of how hypertension is managed and treated in Black churchgoers. Religion plays an integral role in the self-care with a chronic disease such as hypertension. The findings have implications for future healthcare professionals, educators, and researchers who care for Blacks with hypertension and are affiliated with a church or a ministry. When creating, developing, and providing care and education, healthcare professionals can incorporate the coping strategies mentioned above based on their religion. Healthcare professionals can suggest prayer, the Bible, and religious social support. Healthcare professionals working in the faith-based setting should incorporate the strategies reported in this article into the interventions that target Blacks with

hypertension. The incorporation of Biblical verses, text, content, and prayer to Black hypertensive patients as an addition to traditional care could be suggested.

Positive Social Change

According to the American Heart Association's 2019 Statistical Fact Sheet, among Blacks age 20 and older, 58.6% of males and 56% of females had high blood pressure. From a public health perspective, the research identified a disparity and inequity in hypertension prevalence and control between Blacks and Whites (Usher et al., 2018; Howard et al., 2018). However, this phenomenon remains to be unknown. There has been no data or research identified that can exclusively explain the disproportionate hypertension incidence and prevalence. This research attempted to explore and understand these reasons. As a result, the research can guide efforts to prevent, manage hypertension and to reduce the disproportionate mortality rate between Black and Whites.

In the United States, there is a gap between the effects and complications of hypertension in Black adults and White adults. The research presented in the literature review identified:

1. Hypertension prevalence contributes to disparities in Black Americans (Howard et al., 2018; Usher et al., 2018).
2. There is a connection between religion, religious attendance, spirituality, and health outcomes (Bruce et al., 2017; Bowe et al., 2017; Dill, 2017; Millet et al., 2018).

3. Black Americans are considered to be the most religious racial/ethnic group in the US (Millet et al., 2018).

This research could be a contributing factor to help address hypertension prevalence in Blacks, specifically churchgoers. The research identified that religion played a vital role within the black community (Campbell & Winchester, 2020). Furthermore, Blacks currently exhibit high rates of hypertension and use religion to cope. From a programmatic perspective, it could be beneficial to address hypertension using religion as a framework to develop an evidence-based intervention, promotion, and education. More so, religion has been identified as a contributor to self-awareness and health awareness with this specific group. This data could be used as the foundation for hypertension intervention and education development. A positive social change could include developing and disseminating an evidence-based hypertension program grounded by religion and administered to Blacks within a faith-based setting.

Research supported the need for public health workers to work with Black churches (Brewer & Williams, 2019; Brand, 2017). Health educators can provide evidence-based education and intervention that use religion as a framework for messaging by incorporating the coping strategies mentioned above. Prayer, the Bible, and religious social support can be suggested for self-care strategies. Programs could include Bible verses, text, and content. In addition to traditional care, individual prayer and group prayer could be incorporated. This research will provide a conceptual framework to use when developing programs, education, and interventions. For public health professionals, independently or collectively, there is a great need to address the prevalence of

hypertension in Blacks. Moreover, given the data displayed here is an opportunity to use religion and religious practices to assist with hypertension self-care in Black churchgoers. After the study submission and approval, it is anticipated that the researcher will share this information with Black faith-based organizations and leaders. The data could empower the Black churches and leaders to be more proactive with a collaborative approach to address the health disparities displayed in its congregations.

Conclusion

The presumption for this study was founded on the data that Blacks suffer disproportionally in the incidence and prevalence of hypertension compared to Whites. The prevalence of HTN in Blacks in the United States is the among the highest in the world (Virani et al., 2021). Hypertension is associated with an increased risk of stroke, coronary heart disease, end-stage renal disease, and kidney disease (Howard et al., 2018). Throughout history, the black church has been considered the most critical institution in the Black community and reported higher levels of religious involvement (Campbell & Winchester, 2020; Teteh, Lee, Montgomery & Wilson, 2019). Considering the Black church has been a place where many Blacks have turned to during times of trouble due to the church's contribution to the development of the historically black university and provided social services (Hankerson, Svob, & Jones, 2018). It has been a constant provider of emotional, religious, spiritual, and social support for people of African descent. In addition, the Black Church historically has provided information, interventions, and advocacy (Stennis et al., 2015). Healthcare professionals have been challenged to understand and demonstrate the need for cultural competence in Black

Churches. The purpose of this study was to understand the influence that religious practices had on Black churchgoers diagnosed with hypertension. This culturally competent research will help promote efforts to conduct more research within Black congregations subsequently leading to the development of effective interventions that positively impact diverse communities.

The findings confirmed that religious practices guided self-care through prayer, the Bible, and social support. These findings are consistent with the literature on the use of religion, religious practices, and coping among Blacks (Polzer and Miles, 2007; Reeves et al., 2012; Lynn, Yoo & Levine, 2014; Hamilton et al., 2013; Namagey-Funa, Muilenburg & Wilson, 2015; Hamilton et al., 2017). All participants reported a positive experience with the use of religious practices in coping and caring for hypertension. As exhibited in the themes, the participants in this study used religious practices daily to endure life situations. This study confirmed that religion has a positive influence on Black churchgoers. The Black church remains an invaluable asset to address public health issues while using a holistic approach. Public health agents, faith-based organizations, and leaders can take a collaborative approach to address the necessary health improvements in the Black community. The researcher hopes to promote culturally competent research that focuses on Blacks, Black Church, and chronic disease prevention that address barriers, challenges, and recommendations presented.

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Appendix A: IRB Informed Consent

CONSENT FORM
[Church Name]

You are invited to take part in a research study about the influence that religious practices have on the self-care of Black Churchgoers diagnosed with hypertension. The researcher is inviting Black American churchgoers, ages 18 years and older, clinically diagnosed with hypertension to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Taquina Davis, who is a doctoral student at Walden University.

Background Information:
The purpose of this study is to understand how religious practices influences the self-care in Black churchgoers diagnosed with hypertension in the Southeastern region of the US.

Procedures:
If you agree to be in this study, you will be asked to:

- Answer various questions that involve describing your personal religion and hypertension experiences.
- Participate in an one time one-on-one audio-recorded interview.
- Agree that your responses will be recorded and kept confidential by the researcher.
- Request recordings and transcripts are available from researcher.

Sample questions include:

- *Which religious practices are important to you?*
- *What is your denomination?*
- *What things do you do to take care of your hypertension?*

Voluntary Nature of the Study:
This study is voluntary. You are free to accept or turn down the invitation. No one at Walden University or [Church Name] will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this study would not pose risk to your safety or wellbeing and at any time, you can refuse to answer the question and end the interview. There are no monetary, incentive or other benefits offered for participating in this study.

The data collected for this research will help healthcare professionals gain a better understanding of how to address hypertension in Black churches. The research will provide a framework that will assist public health organizations create programs and interventions for this specific population.

Privacy:
Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by a password protected database that is only accessible by the researcher. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via phone (803)528-5090 or email Taquina.davis@waldenu.edu. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at Walden University via telephone number 612-312-1210. Walden University's approval number for this study is **IRB will enter approval number here** and it expires on **IRB will enter expiration date.**
The researcher will give you a copy of this form to keep.

Obtaining Your Consent
If you feel you understand the study well enough to make a decision about it, please indicate your consent by signing below.

_____ _____
Printed Participant's Name Date

_____
Participant's Signature

_____
Researcher's Signature

Appendix B: Interview Guide

[Introductions – *small talk*]

Good day, first I would like to say *thank you* for taking the timeout to meet with me. My name is Taquina Davis and I am currently a Ph.D. student at Walden University. I am in the data collection phase of my study. The purpose of this meeting is to get a better understanding of the influence of religious practices in Black churchgoers with hypertension.

Everything that we say during this meeting will be confidential and that the information that you share with me will not be shown to anyone else. Your information will be kept completely private. At any time you feel uncomfortable or want to stop, you are free to do so. The questions that I will be asking will revolve around blood pressure and religion.

I will be recording our conversation with my phone. I will use the information that I gather to help with my research. Please be reassured that your information will be kept private and will not be shared with anyone else. Do you have any questions?

Is it okay if we begin?

[Demographic and Background Questions]:

A. May you please provide me with the initial of your first name and then your full last name?
B. How old are you?
C. Are you African American, not Hispanic?
D. Are you male or female?
E. What is your highest level of education?
F. What is your employment status?
G. What is your religion?

H. What is your denomination?

I. On average, how many days per week do you go to church?

J. Have you been clinically diagnosed by a physician as having high blood pressure?

K. If so, how long have you been diagnosed?

[Blood Pressure & Religion Questions]: *Open-ended*

1. Can you describe your religion?
2. What role does religion play in your life?
3. Which religious practices are important to you?
4. How often do you incorporate religious practices into your daily life?
5. What are some of your beliefs regarding religion and health?
6. What things do you do to take care of your hypertension?
7. How do you feel about the idea of managing your hypertension?
8. What religious practices make it easy for you to manage your hypertension?
9. What things make it hard for you to manage your hypertension?
10. How does your religion connect with the management of your hypertension?
11. Is there anything else you would like to tell me?
12. Can I contact you if I need any additional information, concerns or questions? If so, what is the best way to contact you?

Closing Statement

These are all the questions I have for you. Again, I would like to say thank you for spending this time with me. This information will be helpful for my research.

Appendix C: Recruitment Flyer

Study for African American adults diagnosed with high blood pressure

Research Participants Required

Research Title: Understanding How Religious Practices Influence Self-Care in Black Churchgoers Diagnosed with Hypertension

Background:

The purpose of this study is to see how religious practices in Black churchgoers diagnosed with high blood pressure influence blood pressure self-care. Your input can contribute to help better understand this social issue.

WALDEN UNIVERSITY
A higher degree. A higher purpose.

This study is being conducted by a researcher named **Taquina "TQ" Davis,** who is a doctoral student at Walden University, Minnesota, USA.

You are the ideal participant if you are:

- African American adult (ages 18 years and older) diagnosed with high blood pressure
- Member or affiliated to a church
- Have not been diagnosed with a terminal illness, mental, or psychological diagnosis or disorder
- Willing to sign a written consent to the study
- Willing to participate in a 30 to 60 minute face-to-face interview

Participation is voluntary and confidentiality will be ensured. If you are interested, please email to TQ Davis at Taquina.davis@waldenu.edu / Subject: Research

High Blood Pressure Study
TQ Davis
803-528-5090
Taquina.davis@waldenu.edu

Appendix D: Letter of Cooperation

Rev. Dr. Patrick Bryant
Senior Pastor
Calvary Baptist Church of Blythewood
716 Sandfield Rd
Blythewood, SC 29016

October 30, 2019

Taquina Davis
Walden University Ph.D. Candidate
1289 Heins Rd
Blythewood, SC 29016

Dear Mrs. Davis:

Based on our conversations, I give permission for you to conduct the study entitled *Understanding How Religious Practices Influence Self-care in Black Churchgoers Diagnosed with Hypertension,* among the membership of **Calvary Baptist Church of Blythewood**. Specifically, **Calvary Baptist Church of Blythewood** will assist with recruitment by promoting it in church announcements, hanging up recruitment flyers at our location, and allowing you to come promote and speak to our members about your research. Individuals' participation will be voluntary and at their own discretion.

We are willing to assist you with your research in any capacity. We will help with recruitment and allow you to host interviews at our location. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with our policies. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of Mrs. Davis' supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Rev. Dr. Patrick Bryant
Senior Pastor

First Lady Christanny Bryant

Appendix D: Letter of Cooperation

Rev. Dr. Willie J. Thompson Jr.
Senior Pastor
Oak Grove Baptist Church
1063 Old Two Notch Rd
Elgin, SC 29045

October 30, 2019

Taquina Davis
Walden University Ph.D. Candidate
1289 Heins Rd
Blythewood, SC 29016

Dear Mrs. Davis:

Based on our conversations, I give permission for you to conduct the study entitled *Understanding How Religious Practices Influence Self-care in Black Churchgoers Diagnosed with Hypertension,* among the membership of **Oak Grove Baptist Church.** Specifically, **Oak Grove Baptist Church** will assist with recruitment by promoting it in church newsletter, hanging up recruitment flyers at our location, and allowing you to come promote and speak to our members about your research. Individuals' participation will be voluntary and at their own discretion.

We are willing to assist you with your research in any capacity. We will help with recruitment and allow you to host interviews at our location. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with our policies. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of Mrs. Davis' supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Rev. Dr. Willie J. Thompson Jr.
Senior Pastor

Appendix E: Interview Transcribe Data Collection Template

Questions	**Interviewee Response**	**Researcher's Notes**
Can I get the initial of your first name and then your full last name?		
How old are you?		
Are you African American, non-Hispanic?		
Are you male or female?		
What is your highest level of education?		
What is your employment status?		
What is your religion?		
What is your denomination?		
On average, how many days per week do you go to church?		
Have you been clinically diagnosed by a physician as having high blood pressure?		
How long have you been diagnosed?		
Blood Pressure & Religion: Open-ended	**Interviewee Response**	**Researcher's Notes**
Can you describe your religion?		
What role does religion play in your life?		
Which religious practices are important to you?		
How often do you incorporate religious practices into your daily life?		
What are some of your beliefs regarding health and illness?		
What things do you do to take care of your hypertension?		
How do you feel about the idea of managing your hypertension?		
What things make it easy for you to manage your hypertension?		
What things make it hard for you to manage your hypertension?		
How does your religion connect with the management of your hypertension?		
Is there anything else you would like to tell me?		
Can I contact you if I need additional information, concerns or questions? If so, what is the best way to contact you?		

Appendix F: Church Announcement Statement

{Church Name] has been asked to participate in a research study. Taquina Davis, PhD student, is conducting a study for her dissertation. Pastor [Pastor Name] has given permission for Mrs. Davis to conduct the study entitled *Understanding How Religious Practices Influence Self-care in Black Churchgoers Diagnosed with Hypertension,* among the membership of **[Church Name]**. Individuals' participation will be voluntary and at their own discretion.

If anyone is interested in participating in Mrs. Davis' study, please contact her personally at (803) 528-5090.